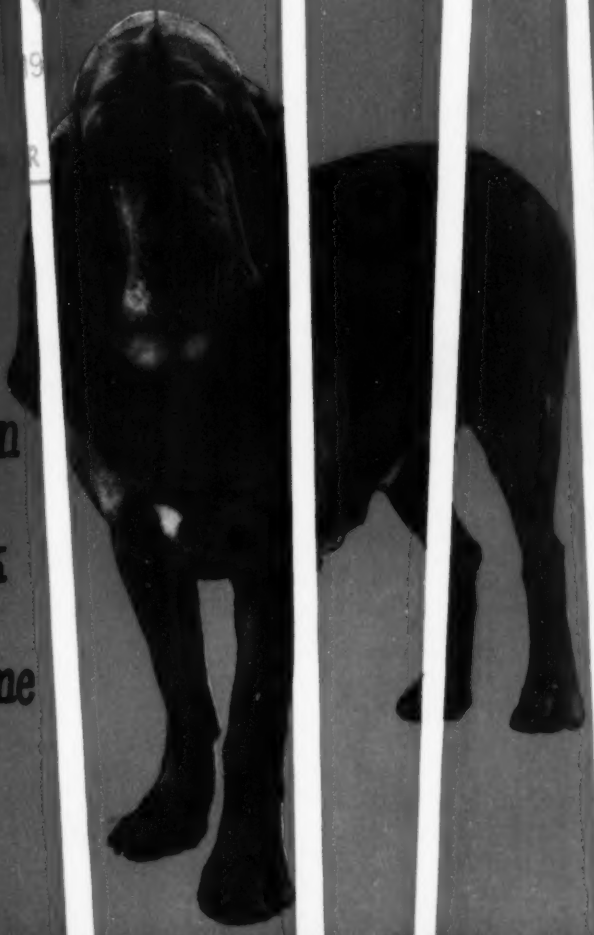
Medical Economics

Published every other Monday • Issue of March 27, 1961

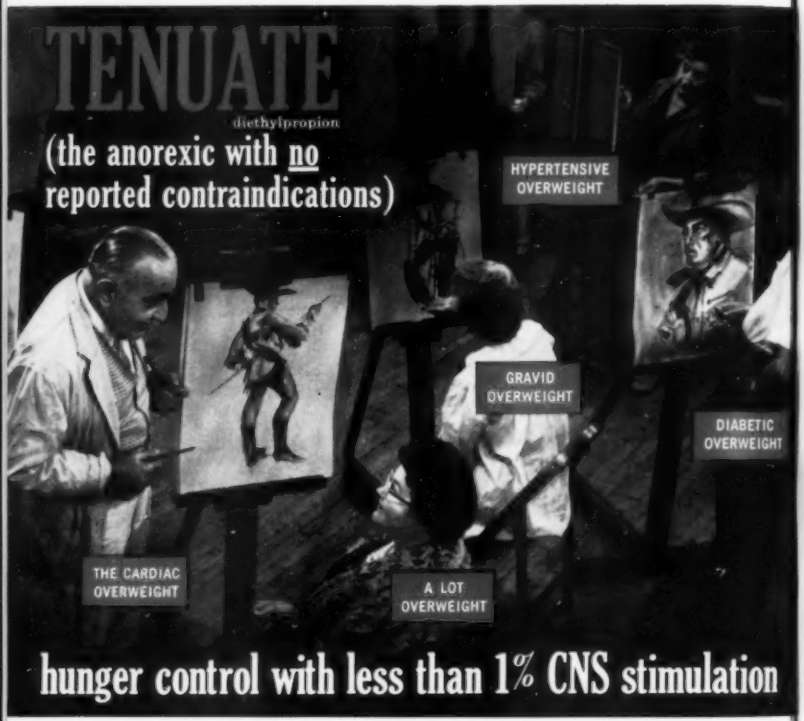
ow the specialties compare financially

ive your patient a written report?



How T-men can check your income

look at all the 'special risk' patients who can use



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What's ahead for you

Medical Economics, March 27, 1961

DON'T EXPECT CONGRESS TO RUSH through President Kennedy's plan to provide health care for the aged under Social Security. Says one high labor official who's also a top strategist in the fight to put over the bill: "I'd like to think the measure will go right through within weeks, but it won't. If Congress passes it at all this year, I don't see how it can do so before July."

IS THE BULL MARKET DUE TO BREAK sharply downward? Not according to the odd-lot theory, which maintains that small investors always act too late. They normally buy 10 per cent more shares than they sell. But now they're selling as many as they buy. Predicts odd-lot theorist Garfield Drew: The major trend is still up.

BETTER STRENGTHEN YOUR GUARD NOW against letting patients run up really large unpaid accounts. The American Bar Assn. reports a 38 per cent rise in the number of families who claimed bankruptcy in the last half of 1960. Chief reason: Because of "easy credit," they got overloaded with bills. Then when illness struck, they were unable to meet the payments.

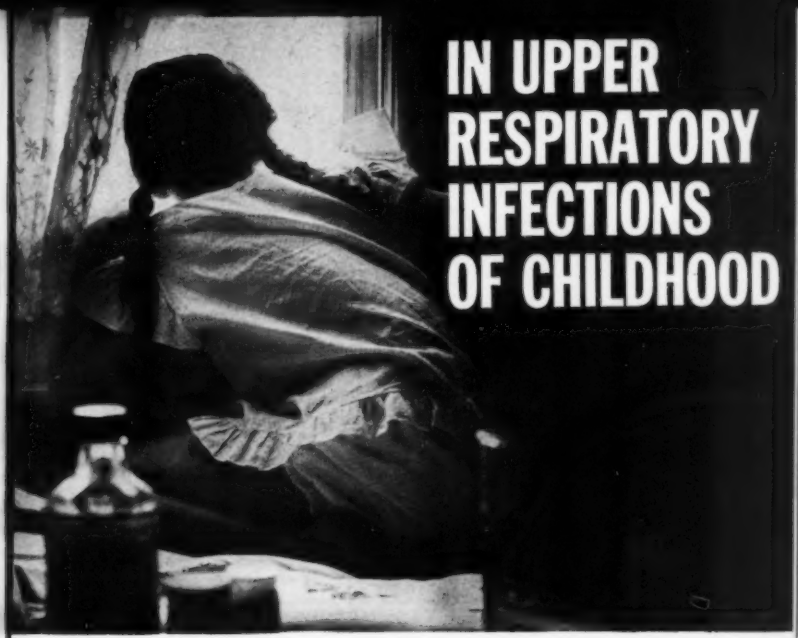
MORE AND MORE DOCTORS WANT A REFERENDUM of A.M.A. members on Social Security for self-employed M.D.s, judging by reactions to recent pro and con articles in this magazine. Sample

comments: "The time is ripe for a poll." "Let's settle this matter, drop it, and give the public something better to read about." "A secret ballot is the only way. If it shows that the majority favors Social Security, the A.M.A. should go to Washington and ask for it."

MUTUAL FUNDS may become better buys for you as they scale down the fees they pay their investment managers. A stockholder suit has just forced the $125-million Lazard Fund to cut its management fees (formerly a flat one-half of 1 per cent of net assets) on all assets over $100 million. Similar suits are now pending against other fixed-fee mutuals.

IF MORE FOREIGN INTERNES FAIL the medical qualification exam that's coming up next week, you may expect the kind of notice handed to staffers at the Newark (N.J.) Beth Israel hospital this month: "Members of the visiting staff, with the exception of Chiefs of Service and Consultants, will (henceforth) be required to write the admitting history and physical examination on all private patients."

YOU'LL BE ABLE TO BUY SEAT BELTS on a 1962 car for only about $13 a pair, little more than half the present cost. To increase use of the safety devices, auto makers plan to include the necessary brackets as standard equipment.



IN UPPER RESPIRATORY INFECTIONS OF CHILDHOOD

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Resistance to antibiotics by a rising number of bacterial strains*—as well as super-infection during antibiotic therapy—poses an increasing problem in the management of upper respiratory infections in children. In the face of these difficulties many clinicians resort to time-tested GANTRISIN, which continues to offer an expedient and realistic approach to pediatric respiratory infections.

Especially useful in pediatric practice (and flavor-designed for children): **Gantrisin Acetyl** Pediatric Suspension and Syrup; **Lipo Gantrisin.**

Consult literature and dosage information, available on request, before prescribing.

*A. J. Vignec and J. G. Kuan, **New York J. Med.**, 60:3030, 1960.

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Anergex is nonspecific in action. Its effectiveness against most common allergens eliminates skin testing and long drawn-out desensitizing procedures. In contrast to the antihistamines and other drugs that provide only temporary symptomatic relief, Anergex induces a prolonged allergy-free state.

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the new concept for the treatment of allergic diseases

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Medical Economics

National business magazine for physicians, March 27, 1961

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You can save money if you buy that foreign car in Europe. But how much do you save? What about the red tape? Here are the answers

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to control inflammation, swelling and pain in ACCIDENTAL TRAUMA and general surgery[1-3]

In a study of 491 cases that included 47 fractures, 45 tonsillectomies, 61 herniotomies and 31 cyst removals, it was concluded that: "chymotrypsin reduces or prevents traumatic and surgical edema and hematoma, accelerates absorption of blood and lymph effusions, reduces pain, promotes wound-healing and may enhance or augment the action of antibiotics."[1]

1. Cigarroa, L. G.: J. Internat. Coll. Surgeons *34*:442, 1960. 2. Teitel, L. H., *et al.*: Indust. Med. *29*:150, 1960. 3. Billow, B. W., *et al.*: Southwestern Med. *41*:286, 1960.

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The spread of specialism has resulted in an economic change of life in medicine during the last ten years. MEDICAL ECONOMICS' Continuing Survey reports on how nine major specialties are doing

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Government, hospitals, labor, and the public are the four forces threatening to make medicine a controlled trade. Here's what doctors are doing to protect their freedom—and what they could be doing

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1. Hayden, G.E.: Am. J. Ob. & Gyn. *76*:271, 1958.

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Your profession (cont.):

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Practice problems on your mind?

Maybe a problem in your office routine has you stumped—about billing, perhaps, or collections, or your aide's duties, or your professional- or patient-relations. Why not put it to the six experts who write the MEDICAL ECONOMICS feature, Practice Management Question Box?

If your query is of profession-wide interest, it may be answered in print—with an advance copy to you. If not, it will be answered by mail.

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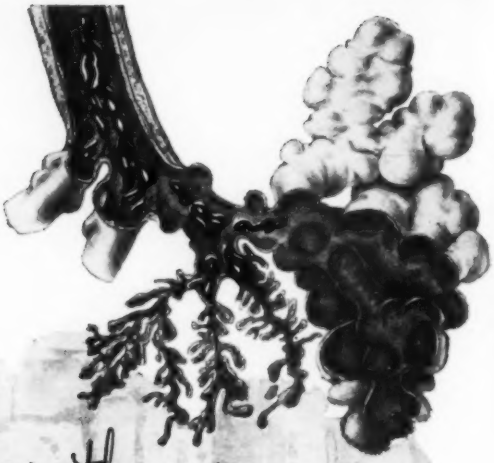

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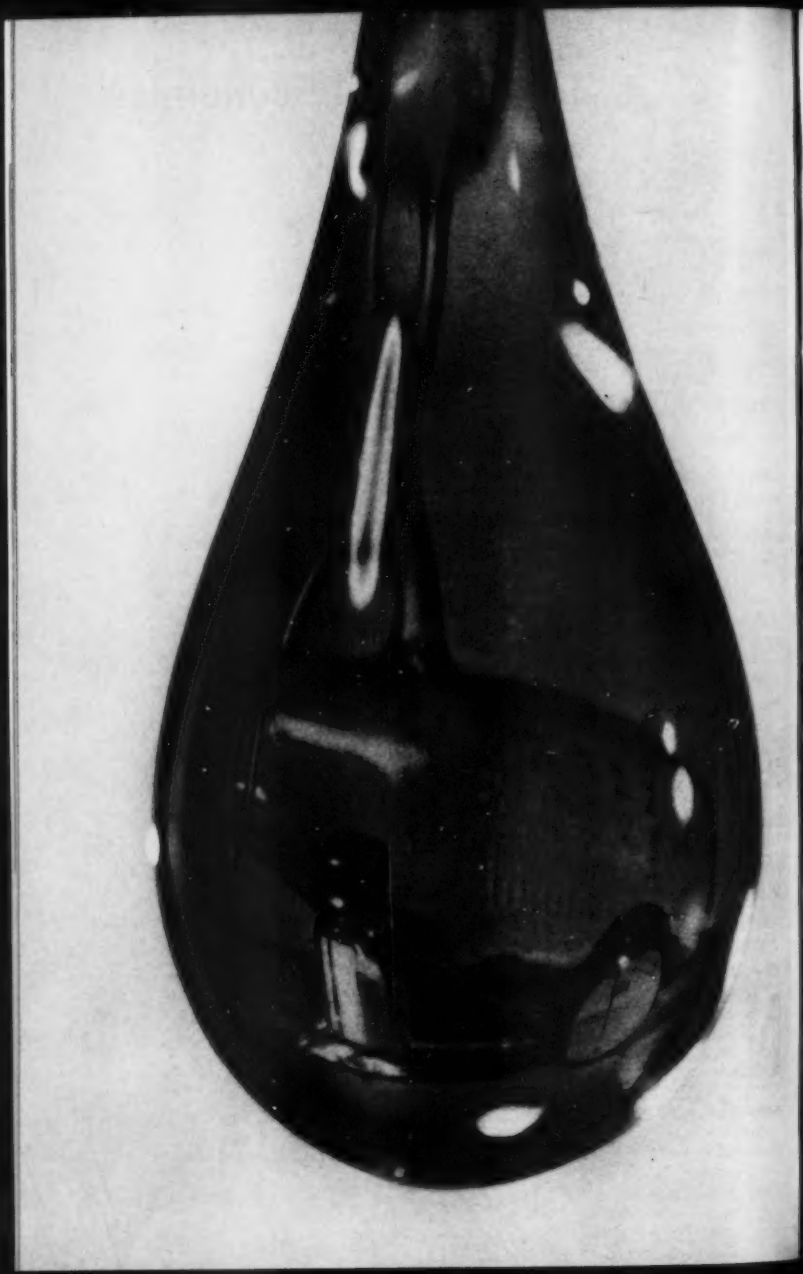

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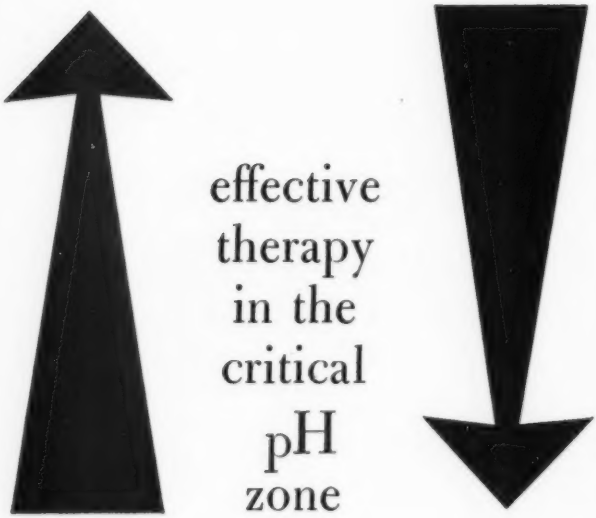

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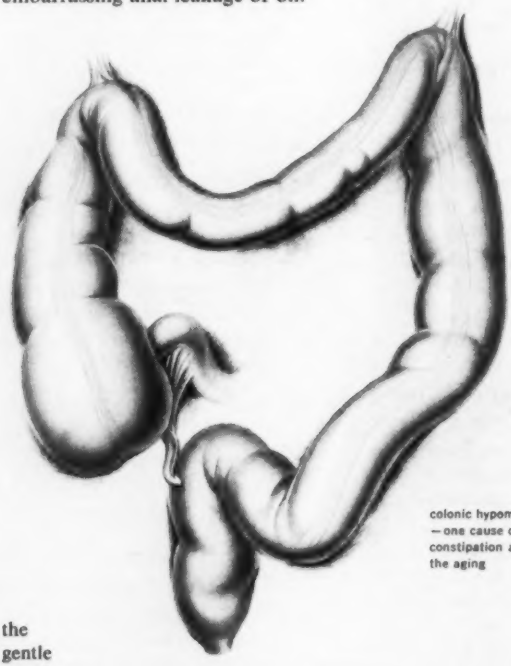

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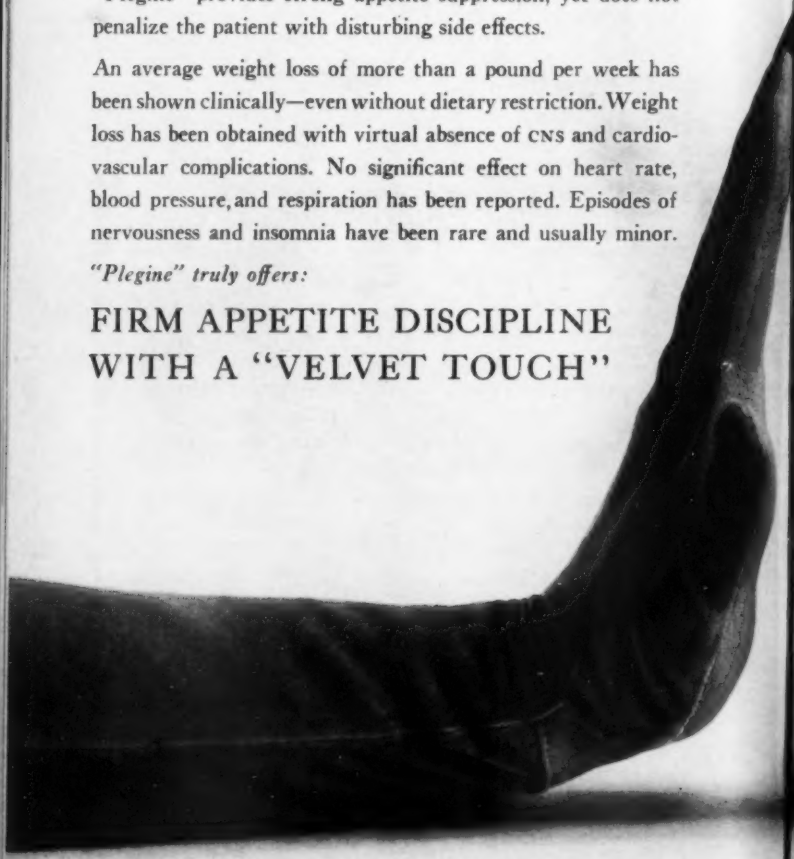

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**References available on request.*

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antibiotic
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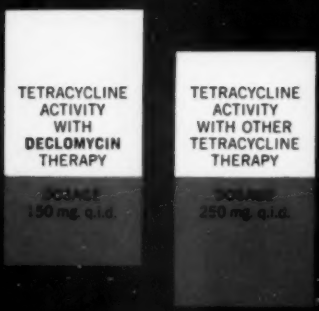
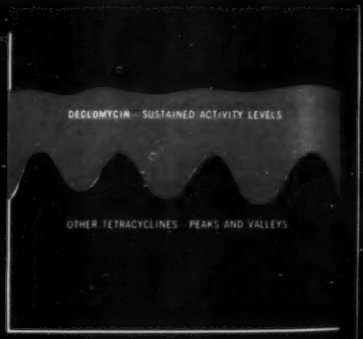


POSITIVE ANTIBACTERIAL ACTION



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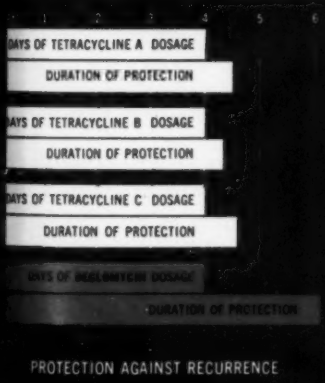


CAPSULES, 150 mg., bottles of 16 and 100. **Dosage:** Average infections—1 capsule four times daily. Severe infections—Initial dose of 2 capsules, then 1 capsule every six hours.

PEDIATRIC DROPS, 60 mg./cc. in 10 cc. bottle with calibrated, plastic dropper. **Dosage:** 1 to 2 drops (3 to 6 mg.) per pound body weight per day—divided into 4 doses.

SYRUP, 75 mg./5 cc. teaspoonful (cherry-flavored), bottles of 2 and 16 fl. oz. **Dosage:** 3 to 6 mg. per pound body weight per day—divided into 4 doses.

PRECAUTIONS—As with other antibiotics, DECLOMYCIN may occasionally give rise to glossitis, stomatitis, proctitis, nausea, diarrhea, vaginitis or dermatitis. A photodynamic reaction to sunlight has been observed in a few patients on DECLOMYCIN. Although reversible by discontinuing therapy, patients should avoid exposure to intense sunlight. If adverse reaction or idiosyncrasy occurs, discontinue medication.

Overgrowth of nonsusceptible organisms is a possibility with DECLOMYCIN, as with other antibiotics. The patient should be kept under constant observation.

LEDERLE LABORATORIES
A Division of
AMERICAN CYANAMID COMPANY
Pearl River, New York

The basic question is whether we are to discard the system that has brought us to our present level of health care, and promises much higher levels for the future, in favor of a regulatory strait jacket that stifles initiative, bureaucratizes research, and promises nothing for the future.

You can't go places in a strait jacket....!

An editorial writer recently made the interesting suggestion that the pharmaceutical industry might have avoided much of the current public interest in its affairs if they had simply restricted themselves to making aspirin tablets and rubbing alcohol, competing only by debating which aspirin dissolves faster. • No one has seriously suggested a return to the "good old days" in therapeutics, but there are apparently some who would like to destroy the system that has produced for us the finest medical care in the history of the world. Whether they attack the freedom of the patient to choose his physician, the freedom of the physician in the practice of his profession, or the freedom of the pharmaceutical industry is immaterial. • If the desideratum is simply maintenance of the status quo in health care, medicine might well have rested on its 19th century laurels and the pharmaceutical industry on aspirin tablets and rubbing alcohol.

This message is brought to you on behalf of the producers of prescription drugs as a service to the medical profession. For additional information, please write Pharmaceutical Manufacturers Association, 1411 K Street, N.W., Washington 5, D.C.

on the pathogenesis of pyelonephritis:

An inflammatory reaction here [renal papillae] may produce sudden rapid impairment of renal function. One duct of Bellini probably drains more than 1000 nephrons. It is easy to see why a small abscess or edema in this area may occlude a portion of the papilla or the collecting ducts and may produce a functional impairment far in excess of that encountered in much larger lesions in the cortex."[1]

The "exquisite sensitivity"[2] of the medulla to infection (as compared with the cortex), highlights the importance of obstruction to the urine flow in the pathogenesis of pyelonephritis. "There is good cause to support the belief that many, perhaps most, cases of human pyelonephritis are the result of infection which reaches the kidney from the lower urinary tract."[3]

to eradicate the pathogens no matter the pathway

FURADANTIN®

Brand of nitrofuranton

High urinary concentration • Glomerular filtration plus tubular excretion • Rapid antibacterial action • Broad bactericidal spectrum • Free from resistance problems • Well tolerated—even after prolonged use • No cross resistance or cross sensitization with other drugs

Average Furadantin Adult Dosage: 100 mg. tablet q.i.d. with meals and with food or milk on retiring. *Supplied:* Tablets, 50 and 100 mg.; Oral Suspension, 25 mg. per 5 cc. tsp.

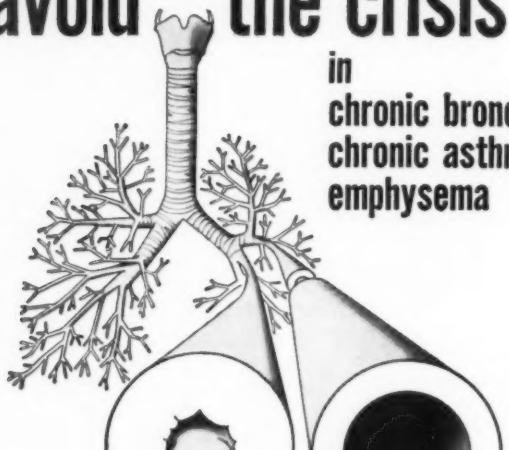
References: 1. Schreiner, G. E.: A.M.A. Arch. Int. M. **102**:32, 1958. 2. Freedman, L. R., and Beeson P. B.: Yale J. Biol. & Med. **30**:406, 1958. 3. Rocha, H., et al.: Yale J. Biol. & Med. **30**:341, 1958.

* NITROFURANS—a *unique* class of antimicrobials

EATON LABORATORIES,
DIVISION OF THE NORWICH PHARMACAL COMPANY, NORWICH, N. Y.

to avoid the crisis

in chronic bronchitis chronic asthma emphysema



Choledyl provides uniformly effective bronchodilatation throughout long-term therapy. Choledyl, taken regularly, helps prevent severe flare-ups in patients with chronic respiratory disease (the aging in particular) by affording continuous relief from debilitating bronchospasm. Gastric irritation and other unwanted effects are rare.

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keeps the airways open

Supplied: 200 mg. tablets (yellow), bottles of 100. *Precautions:* Side effects have been minimal but may include CNS stimulation or, rarely, palpitation. *Full dosage information, available on request, should be consulted before initiating therapy.*

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Professional briefs

Medical Economics, March 27, 1961

SHOULD YOU CHARGE EXTRA FOR HYPNOSIS if you use it in your practice? At least one state medical society (California's) has resolved that doctors shouldn't. But a new survey by this magazine shows that 57 per cent of doctors who use hypnosis do charge extra for it. Their median fee: $10 per session.

STAY ON YOUR PEDESTAL, suggests Emanuel Demby, a motivation researcher. He takes a dim view of colleagues who urge doctors to use first names of patients and to treat them as buddies. Demby says: "If people finally embrace the picture of the doctor as a glad-handing business man, soon they'll have a caveat emptor feeling about medicine, and they'll want him regulated by a Government commission."

YOU CAN MAKE YOUR COLLECTION LETTERS more effective, says American Collectors Assn. Executive Secretary John Johnson, if you close with a specific request such as "please call me by Friday if you're unable to arrange payment." If there's no response, this clears the way for your aide to call and find out why.

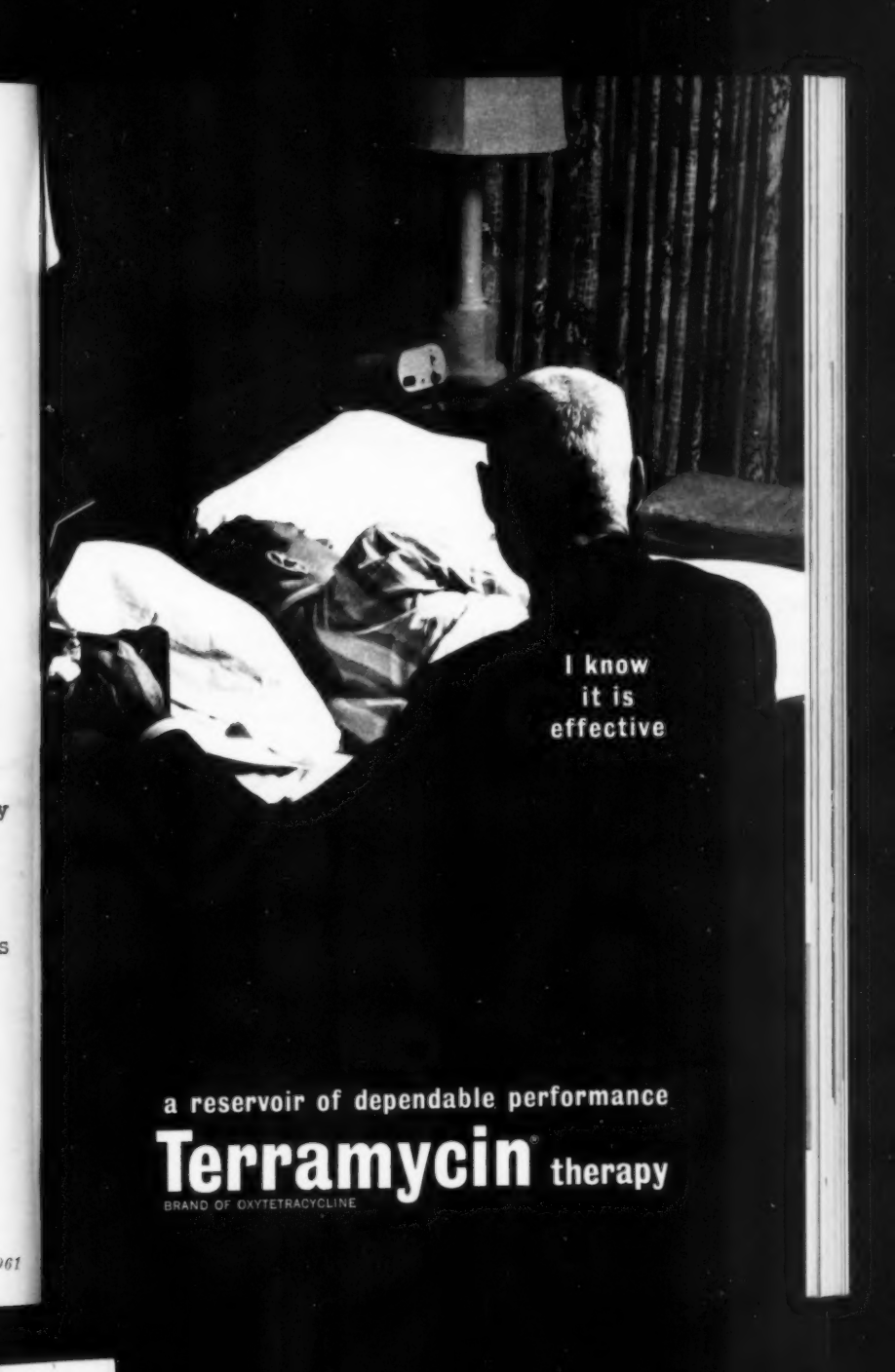
A UNIONIST'S BLAST AGAINST A DOCTOR has backfired. Three years ago, Warren Draper, chief medical officer of the United Mine Workers, strongly criticized Dr. James Donnelly of Trinidad, Colo., for the latter's

campaign to keep U.M.W.-employed doctors out of the local medical society. Dr. Donnelly, claiming slander, sued the U.M.W. for $4 million. A few weeks ago, the union agreed to settle the case for $40,000.

IF YOU'RE AN ATTENDING STAFFER in a non-teaching hospital, be sure you don't delegate any medical duties to an externe. Since he is legally a lay employe, warns the A.M.A. Law Department, it's a violation of the Medical Practice Act to give him any medical tasks. Also, if a female disrobes for an examination by an externe, she may have grounds for suit.

TOO MUCH COMPETITION AMONG DOCTORS breeds bad health plans along with good ones. That's not the case in Manhattan, says the New York County medical society. "Anyone can create almost any kind of system of practicing medicine and of paying for it," the society notes, as long as there are doctors "crazy" enough to accept its controls. The city has such doctors because it's overrun with M.D.s; one for every 250 persons.

DOCTORS WHO SERVE on medical disciplinary committees often risk a civil suit if they take action against a colleague. Now a bill has been introduced in California to grant members of such committees civil immunity on a decision that's reasonable and without malice.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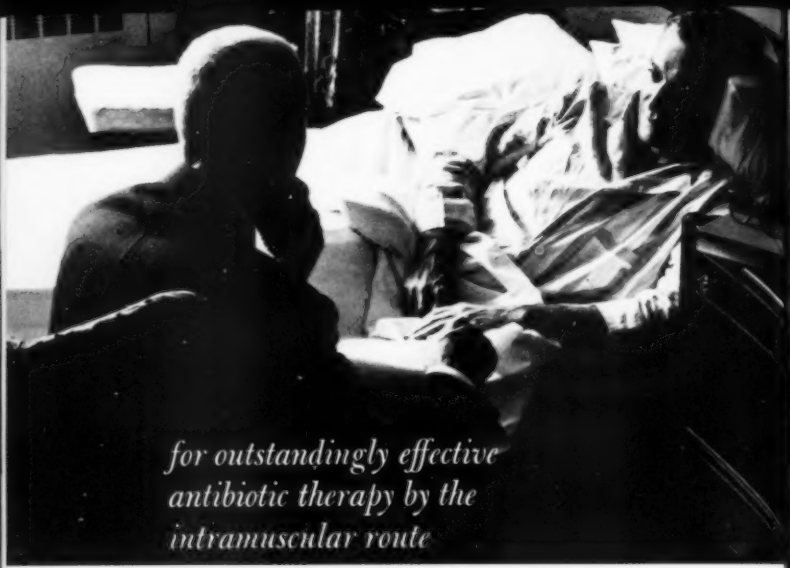
BRAND OF OXYTETRACYCLINE



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INTRAMUSCULAR SOLUTION

In today's Terramycin Intramuscular Solution, the qualities responsible for the continuing effectiveness of Terramycin therapy are enhanced by a degree of convenience and dosage flexibility hitherto available only with narrow-spectrum antibiotics. Terramycin Intramuscular Solution is conveniently preconstituted, and is available in 10 cc. multi-dose vials and 2 cc. ampules. A recent experimental study† has demonstrated outstanding tissue toleration following I.M. administration.

†*Terramycin Therapy*, p. 7, New York, Pfizer Laboratories, 1960.

IN BRIEF

The dependability of Terramycin® is based on outstanding antimicrobial effectiveness, notably wide distribution in body tissues, excellent toleration, and low order of toxicity. Terramycin Intramuscular Solution, a *preconstituted* parenteral form of oxytetracycline with 2% Xylocaine* as a local anesthetic, facilitates prompt initiation of broad-spectrum antibiotic therapy when indicated. There is a notably low incidence of pain at the injection site. The dosage flexibility made possible by the new 10 cc. multi-dose vial is of particular advantage in pediatrics.

INDICATIONS: All oxytetracycline indications whenever initial or continuing therapy with I.M. injection is chosen. Compatible oral therapy may then be given with Cosa-Terramycin® Capsules, Cosa-Terrabon® Oral Suspension or Cosa-Terrabon Pediatric Drops. Effective against both gram-positive and gram-negative bacteria, rickettsiae, spirochetes, and large viruses, Terramycin therapy is indicated in a great variety of infections due to susceptible organisms, e.g., infections of the respiratory, gastrointestinal, and genitourinary tracts, surgical and soft-tissue infections, ophthalmic and otic infections, and many others.

ADMINISTRATION AND DOSAGE: For intramuscular injection only. Adults: Unless otherwise specified, a dose of 100 mg. every 8-12 hours, or a single daily dose of 250 mg. should be adequate for most mild or moderately severe infections. In *severe* infections, 100 mg. every 6-8 hours or 250 mg. every 12 hours may be necessary. Infants and children should receive proportionately less in accordance with age and weight of patient, and severity of infection.

SIDE EFFECTS AND PRECAUTIONS: Aside from occasional mild pain at injection site, adverse reactions (including allergic) have been rare. As with all I.M. preparations, injection should be made within the body of a relatively large muscle. After insertion of needle, aspiration should be attempted before injecting to avoid inadvertent administration into a blood vessel; care should always be taken to avoid injecting into a major nerve or its surrounding sheath. Subcutaneous and fat-layer injection may cause mild pain and induration, which may be relieved by an ice pack.

Use of antibiotics may result in an overgrowth of nonsusceptible organisms—particularly monilia and resistant staphylococci. If a new infection caused by a resistant pathogen appears, discontinue the medication and institute appropriate specific therapy as indicated by susceptibility testing.

SUPPLIED: *Terramycin Intramuscular Solution,* 10 cc. multi-dose vial, 50 mg./cc., also available as 2 cc. prescored glass ampules, containing 100 mg. or 250 mg., packages of 5 and 100. For rapidly fulminating or critical infections—*Terramycin Intravenous,* in vials of 250 mg. and 500 mg. (buffered with 1 Gm. and 2 Gm. ascorbic acid, respectively). In addition, a variety of other systemic and local dosage forms are available to meet specific therapeutic requirements—including *Cosa-Terramycin® Capsules, Cosa-Terrabon Oral Suspension and Cosa-Terrabon Pediatric Drops.*

More detailed professional information available on request.

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Lifts depression...as it calms anxiety

Smooth, balanced action brightens mood, restores normal sleep...rapidly and safely

Balances the mood—no "seesaw" effect of amphetamine-barbiturates and energizers

Acts swiftly—the patient soon returns to her normal activities

Acts safely—no danger of liver or blood damage

Dosage: Usual starting dose is 1 tablet q.i.d. When necessary, this dose may be gradually increased up to 3 tablets q.i.d.

Composition: 1 mg. 2-diethylaminoethyl benzilate hydrochloride (benactyzine HCl) and 400 mg. meprobamate.

Supplied: Bottles of 50 light-pink, scored tablets. Write for literature and samples.

▲Deprol▲

CD-3577

WALLACE LABORATORIES/*Cranbury, N. J.*

Letters

Medical Economics, March 27, 1961

Another tax crackdown

SIRS: "These Tips Will Ease Your Quarterly Tax Payments" was very timely. This year, for the first time in our experience, the I.R.S. is checking closely on quarterly tax payments and exacting penalties if they're insufficient. Your readers might like to know this before estimating their income and their income taxes for 1961.

—John C. Post

Professional Business Management, Inc.
Washington, D.C.

Malpractice Rx

SIRS: Dr. Kastine's story "My Pay for Saving a Life: a Malpractice Suit!" makes me wonder what can be done about those patients who bring suit as a shrewd way to avoid paying doctor bills. One way to stop them would be to make it a legal requirement that a receipted bill must be obtained before a malpractice suit could be started. This is standard procedure in some other legal proceedings, as I found out recently when I tried to recover for auto damages. I couldn't begin suit until I had a receipted bill stating what work had been performed. Why shouldn't our medical societies lobby for this change in the laws governing malpractice suits?

—Carl T. Javert, M.D.

New York, N.Y.

SIRS: . . . Dr. Kastine registers hurt surprise at being sued. Why? We doctors offer our services for money; we shouldn't insist upon gratitude too. We are not fully commercial, nor are we purely humanitarian, but it's wrong to claim the benefits of both areas.

—M.D., Washington

SIRS: . . .In previous years, our city of 100,000 seldom had a malpractice suit. Now we have several each year. We need more articles like Dr. Kastine's.

—C. A. Carabello, M.D.

Reading, Pa.

Action on aged

SIRS: "Can the A.M.A. Block Federal Medicine?" made me realize it's not enough to be *against* Forand-type laws or *for* Kerr-Mills. We doctors must take the lead in suggesting more specific solutions to the aged's

health-care problem. For example, why shouldn't we support a plan under which our different states would use Kerr-Mills money to purchase Blue Shield-Blue Cross coverage for needy old people? This would be tangible evidence of our profession's sincere wish to provide workable answers.
—M.D., New York

Bonding employes

SIRS: Another reason why "Bonding Your Employes Is Plain Good Sense" is this: It gives you a way to have your aide thoroughly checked at small cost—and without your seeming too personal.
—George Zavadil
P.M., Inc.
Baltimore, Md.

Referral problems

SIRS: "Fine Points in the Art of Referring" suggested the G.P. send along the patient's records. I'm always glad to supply consultants with any information on medicine or laboratory reports by phone, if they want it. But I've never forwarded my patients' records. I feel that it's the consultant's duty to start at the bottom and draw his own independent conclusions.
—James L. Rush, M.D.
Bay Village, Ohio

SIRS: . . . This type of article is most welcome. It's hard to get an open discussion of referral problems among the doctors themselves.
—James A. Burdette, M.D.
Knoxville, Tenn.

SIRS: . . . As a consultant, I've been guilty of some of the errors mentioned. But while we certainly shouldn't go back to the frock-coated formality of the old-time consultant, we could use a little more common courtesy on the part of referring physicians.
—Buford S. Chappell, M.D.
Columbia, S.C.

SIRS: . . . Referral problems have divided us into two separate camps: G.P.s in one, specialists in the other. It's time we stopped taking pot shots at each other.
—Arthur C. Signer, M.D.
New Hyde Park, N.Y.

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How modern is your medicine?

Modernism doesn't always spell good medicine, but patients tend to think it does. This informal survey reveals ten characteristics that people want in a 'modern' doctor

By *Henry A. Davidson*, M.D.

People get sentimental about the horse-and-buggy days. But as a rule, they don't want a horse-and-buggy doctor. Listening to patients' conversations, you'll hear them praise Dr. A because he's up-to-date and criticize Dr. B for being old-fashioned. Their preference for modernism appears to spring from a simple syllogism: Medical knowledge and skill are improving all the time. Diseases are easier to recognize and treat today. Therefore, the more up-to-date a doctor is, the better.

Two years ago, I came across a Columbia University study that said *doctors* judge another doctor's modernity by three criteria: (1) his acceptance of new drugs; (2) his recognition of the emotional factor in illness; (3) his letting the patient share in the treatment. I've since used the Columbia report as a springboard to question *patients* on the subject. "What signs lead

you to believe that a doctor is old-fashioned—or up-to-date?" I ask.

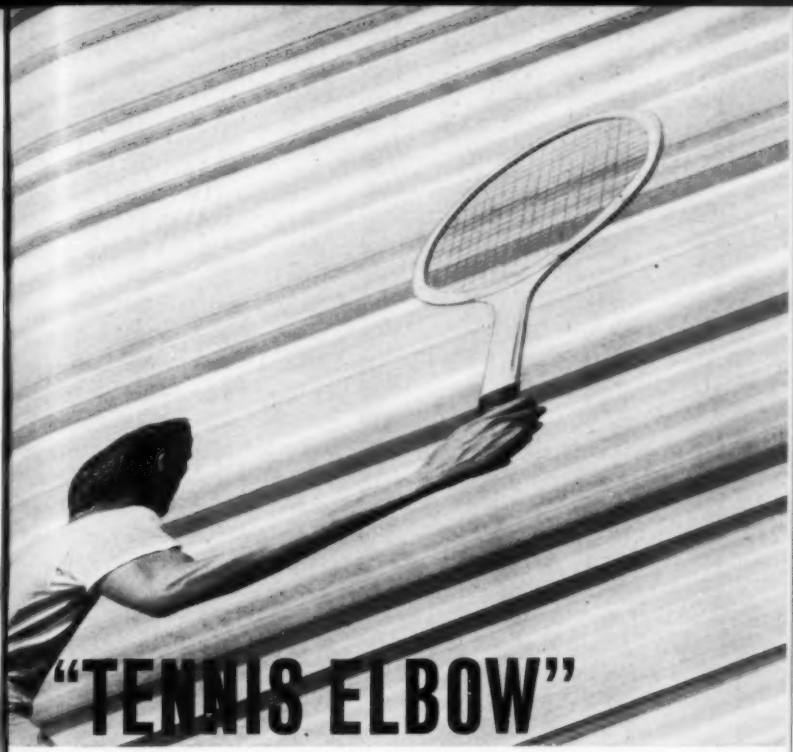
By now, I've talked with dozens of laymen, most of them college graduates in their middle years. A less sophisticated group might have given different answers. But I think of those I've interviewed as pace-setters. Starting off with the three Columbia findings, here is what medical modernism means to the people queried by me.

1. Acceptance of new drugs. Most of the patients regard promptness in prescribing new pharmaceuticals as a sure sign of modernism. No reputable manufacturer, they feel, would release a drug before it's been proved effective and safe. If the doctor doesn't prescribe it because last year's drug is "good enough for me," he's no better in the patients' eyes than the doctor who uses bromides because his grandfather did.

2. Recognition of the emotional factor in illness. Patients notice this, for example, in the way a peptic ulcer is treated. They've come to believe that while medical treatment may stop the symptoms, it won't cure the disease unless there's emotional re-education, too. Here are two illustrations:

A constipated and somewhat depressed woman abandoned her family doctor—a colleague of mine—because he treated her simply by prescribing cascara sagrada. On consulting an internist she'd heard was "psychosomatically oriented," she learned the reasons for her depression. She then was given an antidepressant drug. Her husband, hearing that this drug can cause constipation, was skeptical. The woman, however, went along with the treatment. Her new doctor, she said, was treating her "the modern way" by attacking her underlying depression.

In another case, a chemical engineer compared Dr. G, his gastroenterologist, with Dr. U, his urologist: "At my first visit, Dr. G questioned me in detail about my daily activities. As I left an hour later, I realized we had scarcely touched on my complaint. Specific symptoms weren't discussed until my second visit; I didn't get the X-ray



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Dosage: 1 or 2 tablets 3 or 4 times daily. The usual precautions of corticosteroid therapy should be observed. Additional information on DECAGESIC is available to physicians on request. Supplied: Bottles of 100. Each tablet contains 0.25 mg. of DECADRON (dexamethasone), 500 mg. of aspirin and 75 mg. of aluminum hydroxide (present as the dried gel). DECAGESIC and DECADRON are trademarks of Merck & Co., Inc.
*"Antidoloritic" describes the relief of pain associated with inflammation—dolor = pain, itic = associated with inflammation.

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series until my third visit. I feel that this is good modern medicine! In my father's day, the X-rays would have come first, and I doubt that I would have been asked for any emotional background data at all.

"A year later," he continued, "I had an attack of renal colic. After I passed the stone, I went to Dr. U. 'When did the pain start?' he asked. 'When did it stop? Any urologic symptoms?' That was all. There was a routine examination, but no discussion of my life or medical history up to that point. To this old-school specialist, I was obviously just a urologic tract and nothing more."

Actually, Dr. U did his job well. But in that patient's eyes, he wasn't "modern," and Dr. G was.

3. Letting the patient share in the treatment. This might be called "buddy-system" medicine, as opposed to medicine in the time-honored "doctor-knows-best" tradition. As the patients I interviewed see it, therapeutic modernism shows up in: the doctor's willingness to interpret symptoms, explain diagnostic terms, clarify treatment plans, tell what he's prescribing, and allow for the patient's personal idiosyncracies and preferences.

This willingness to clarify pathology is closely allied with another admired characteristic: the doctor's acceptance of public education in medicine. The enlightened medical man, in the modernist's view, isn't bothered when magazines and TV attempt to give the public the medical facts of life. He doesn't feel people were better off when they were awed by the mystique of medicine. Personally, he's doing all he can to dispel that mystique.

4. Willingness to send the pa-

tient away without a prescription. I get the impression that Britain's National Health Service is turning the English into a nation of medicine bottle tipplers. Why? Because unsophisticated people feel cheated if they don't get medication, and British medicine apparently can't escape the lowest common denominator. Most of the more sophisticated Americans I've interviewed, on the other hand, feel pleased when a doctor advises they don't need medication. Such a doctor is considered modern; he's treating them as adults.

5. Freedom from sanctimony. The conventional explanation for the drop in our profession's reputation is that we've become too impersonal, too interested in fees, and too hard to see. Shrewder observers criticize us for our sanctimony. They say the doctor's traditional importance has led him to adopt an air of self-righteousness that they just can't abide. They're irritated beyond words by any M.D. who emphasizes the charity work he does, his long hours, his devotion to the public good, his being above commercial interests. Since our modus vivendi is so different from that of the clergyman, people don't object to our present prosperity—just to any hint of sanctimony about it.

6. The youth of the doctor. Many people have caught on to the fact that today's doctor-in-training gets more psychiatric grounding than his last-generation counterpart ever did. An American Psychiatric Association study shows that of doctors who received their M.D.-degrees in 1929 or earlier, only 43 per cent are psychiatrically oriented. Yet among the class of 1945 and their juniors, the proportion is 81 per cent. This gives younger men the edge in one important segment of modernism.

Does that mean that most people prefer younger doctors? Not at all. Those I've talked with balance a young doctor's psychiatric savvy with his lack of savvy about some other things. But youth per se is still an advantage, other things being equal.

7. The prestigious board diploma. Is it important for a spe-

cialist to be a diplomate? Sophisticated patients tell me they think so. They have yet to learn that there are fine practitioners in all specialties who have never sought a board diploma—and that there are also some mediocre practitioners who have such a document.

8. Willingness to stick one's neck out. Caution is traditionally associated with conservatism. "He wasn't adventurous enough, medically speaking," a friend of mine said in explaining why she left her former physician. This woman—and some others I've questioned—hold that boldness is evidence of being modern.

9. Good-humored acceptance of paper work. Filling out forms is a time-consuming nuisance, as many of us see it. But it's also a necessary part of modern life. Doctors who accept the fact that forms are here to stay and fill them out without evident annoyance are classed among the up-to-date.

10. Ample office staff, adequate office furnishings. "When a doctor takes down the routine parts of my history—including the family and financial data—I'm flattered by the personal attention. But I do think it's a bit old-fashioned," one woman told me. "In a modern medical office, I expect to give these details to an aide. A doctor's time can't be too valuable if he spends it in recording such data." Having enough help thus becomes a badge of modernism.

So does having the right office furnishings. You may feel the following are superficial criteria; but most of the people I've interviewed have commented on them. They consider a doctor to be contemporary-minded if his office contains light, comfortable furniture; clean, recent-issue magazines; surgical instruments hidden in drawers rather than visible in glass cabinets; and an uncluttered desk in the consultation room.

While these ten tokens of modernism are not necessarily criteria of good medical practice, the public seems to *think* they are. My interviewees say they feel much safer and more comfortable in the hands of doctors who exhibit these "modern" traits. END

HOW RELA BREAKS TH

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ANALGESIC: RELA "... diminished the need for administration of analgesic drugs [aspirin, codeine, meperidine]."[1]

MOBILIZATION: RELA restores mobility by relieving pain, stiffness and spasm.

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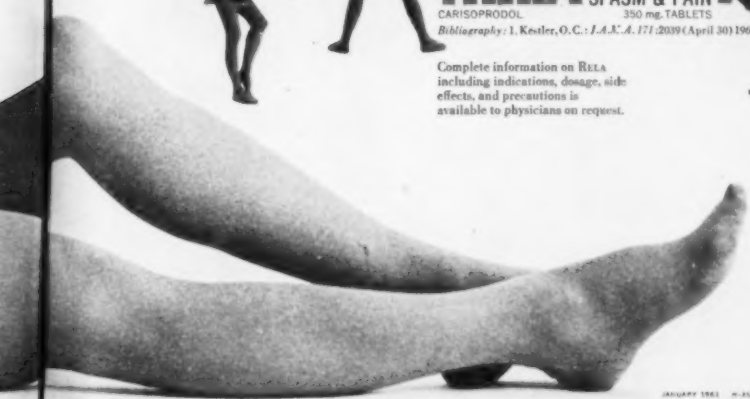
RELA™ RELAXES, EASES ACUTE MUSCLE SPASM & PAIN

CARISOPRODOL 350 mg. TABLETS

Bibliography: 1. Kestler, O.C.: *J.A.M.A.* 171:2039 (April 30) 1960.

Complete information on RELA including indications, dosage, side effects, and precautions is available to physicians on request.

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pplied: 10-mg. scored tablets, bottles of 30. *Reports to artment of Clinical Investigation, Parke, Davis & Company, 8 and 1959.

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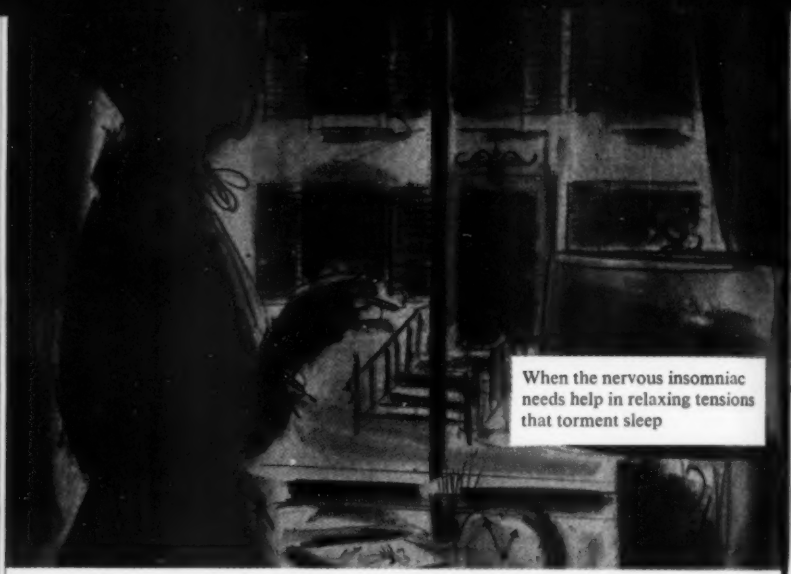
PARKE, DAVIS & COMPANY, Detroit 32, Michigan

OYD (oxymetholone, Parke-Davis), 17 beta-hydroxy-2-hydroxymethylene-17-alpha-methyl-3-androstanone, g. grooved tablets. *Indications:* Negative nitrogen balance as in asthenia, carcinomatosis (except prostatic ormal, chronic diseases (osteoporosis, tuberculosis, sprue, Still's disease), following surgery, severe infec- severe burns, and fractures, also preoperatively, especially in debilitated patients, and to stimulate appetite eight gain in the underweight. *Dosage:* Orally, before or with meals, for 10 to 20 days, up to six months if ssary but generally not over 90 days. Adults—15 mg. daily, adjusted to 10 to 30 mg. as indicated. Prepubertal ren—5 to 10 mg. daily, older children, adult dose if necessary. Because ADROYD retains some androgenicity, ures with all androgens the tendency to salt retention. Use with caution in presence of cardiac disease and ic damage. Contraindicated in prostatic carcinoma, nephritis, and nephrosis. Liver function tests are useful owing hepatic function during therapy. Observe the young and preadolescent for possible masculinization. ued on p 588



When the nervous insomniac needs help in relaxing tensions that torment sleep

Daytime therapy for tension insomnia avoids "knockout" pills at night

What is this daytime therapy? It is the daytime use of Meprotabs (meprobamate) to stop nervous tensions from building up to the point where they keep the patient awake at night.

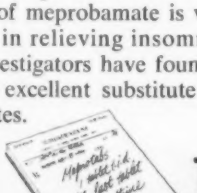
Has it been thoroughly studied? Yes. Over 20 published clinical reports† have proved that the daytime use of meprobamate is very effective in relieving insomnia. Many investigators have found it to be an excellent substitute for barbiturates.

What are its chief advantages? It eliminates the need for the "knockout" hypnotics at bedtime. The patient is relaxed and drifts easily into a sound sleep whenever he wants to. Meprotabs allows the patient to awaken alert and refreshed. There is no mental fogginess to confuse the patient at work.

Dosage: 1 tablet t.i.d. with last tablet at bedtime.

Supplied: White, coated 400 mg. tablets of meprobamate; bottles of 50.

†Bibliography available on request.



Meprotabs* meprobamate tablets

WALLACE LABORATORIES / Cranbury, N.J. *TRADE-MARK

CMT-3712

Practice management question box

The queries below are selected from many that doctors have addressed to MEDICAL ECONOMICS in recent weeks. The answers reflect the judgment of a panel of two physicians and four management consultants. Further Q.s and A.s will appear in forthcoming issues. If you have a question of general interest to your colleagues, you're invited to submit it.

Q. When you charge for reports to a lawyer, whom do you charge? Do you charge the lawyer personally, do you submit it as part of the patient's bill, or what? I've had lawyers request that the charge for the report be buried in the charges for medical services.

A. You'd be better off to refuse any such request. The person who asks for a service should be charged for it. If an attorney asks for a report, the report should be furnished with a bill for it addressed to him.

Q. My biggest problem is collecting fees. There's a small claims court in my area. Should I use it for collecting long-overdue accounts?

A. With the aid of a small claims court, you *may* get a little more money. But the only time most management men counsel a doctor to take a small collection case to court is when the delinquent debtor is the estate of a deceased patient. Then there's no problem in personal relationships; you simply compete with other creditors for the money, and sometimes you can't get it any other way.

Q. I haven't changed my fees since I started practice nine

FOR THE HYPERTENSIVE...

HYPERTENSIVE INVALIDISM:

- headache
- dizziness
- palpitations
- tachycardia
- anginal pain
- anxiety
- organic changes
- edema
- restricted salt intake

THE DIFFERENCE

E BECOMES MORE LIVABLE WHEN YOU PRESCRIBE

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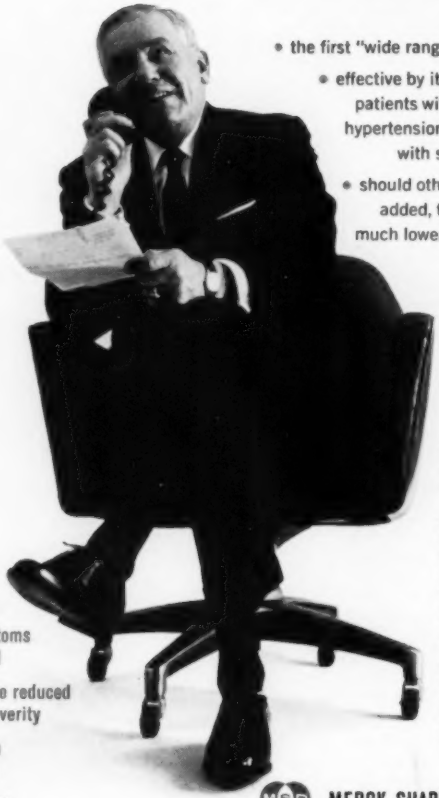
DIURIL® (CHLOROTHIAZIDE) **WITH RESERPINE**



- the first "wide range" antihypertensive
- effective by itself in a majority of patients with mild or moderate hypertension, and even in many with severe hypertension
- should other drugs need to be added, they can be given in much lower than usual dosage

DIUPRES-250
250 mg. DIURIL chlorothiazide, 0.125 mg. reserpine per tablet. One tablet one to four times a day.*

DIUPRES-500
500 mg. DIURIL chlorothiazide, 0.125 mg. reserpine per tablet. One tablet one to three times a day.*

*It is essential to reduce the dosage of other antihypertensive agents, particularly the ganglion-blockers, by at least 50 per cent immediately upon addition of these agents or of Diupres Tablets to the regimen.

Before prescribing or administering DIUPRES, the physician should consult the detailed information on use accompanying the package or available on request.

RE NORMAL
E:

- ertensive symptoms usually relieved
- inal pain may be reduced ncidence and severity
- iety and tension usually allayed
- anic changes may arrested or reversed
- tary sodium can ally be liberalized

DIUPRES

MSD **MERCK SHARP & DOHME**
DIVISION OF MERCK & CO., Inc., WEST POINT, PA.

What's she doing that's of medical interest?

She's drinking a glass of pure Florida orange juice. And that's important to her physician for several reasons.

How your patients obtain their vitamins or any of the other nutrients found in citrus fruits is of great medical interest—because there are so many substitutes and imitations for the real thing.

Actually, there's no better way for this young lady to obtain her vitamin C than by doing just what she is doing, for there's no better source than oranges and grapefruit ripened in the Florida sunshine.

We know that a tall glass of orange juice is just about the best thing a patient can reach for when he or she raids the refrigerator. We also know that if you encourage this refreshing and healthful habit among your patients of any age, you'll be helping them to the finest between-meals drink there is.

Nothing has ever matched the quality of Florida citrus—watched over as it is by a State Commission that enforces the world's highest standards for quality in fresh, frozen, canned, or cartoned citrus fruits and juices.

That's why the young lady's activities are of medical interest.

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'STRASIONIC' ANTICHOLINERGIC METHSCOPOLAMINE-TUAZOLE® RESIN

Just 2 Capsules a Day

Heartburn
Hyperacidity
Painful Spasm
Nocturnal Pain
Gastroenteritis
Peptic Ulcer

A single capsule dose Akalon-T calms the GI tract, combats hypersecretion of pepsin as well as acid for 8-12 hours. Release of Akalon-T is uniform and predictable, since it is unaffected by fluctuations in pH, enzymatic activity, or motility. Your patient is "on the way" with just 2 capsules a day.

'Strasionic' release makes the BIG difference

AKALON-T '5': 5 mg. Methscopolamine and 20 mg. Tuazole (Brand of 2-methyl-3-orthotolyl-quinazolone) as cation exchange resin complexes of sulfonated polystyrene.

AKALON-T '10': 10 mg. Methscopolamine and 40 mg. Tuazole (Brand of 2-methyl-3-orthotolyl-quinazolone) as cation exchange resin complexes of sulfonated polystyrene.

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For detailed brochure write Medical Service Department

Akalon-T—made and marketed ONLY by **STRASENBURGH**

she's probably in your waiting room now, Doctor—still complaining of "nervous indigestion"

The symptoms that give rise to chronic complaints of "nervous indigestion" may have multiple causes. If your dyspeptic patient is fretful and you find gastrointestinal spasm and a deficiency of digestive enzymes, Donnazyme is indicated. It improves many sources of "nervous indigestion" by calming emotions, relieving GI spasm, and supplementing insufficient digestive enzymes.

Donnazyme contains the equivalent of one-half of a Donnatal® tablet plus digestive enzymes in a specially constructed tablet-within-a-tablet that insures the release of its ingredients at the gastrointestinal level where they are therapeutically most beneficial. In the gastro-soluble outer layer: hyoscyamine sulfate, 0.0518 mg.; atropine sulfate, 0.0097 mg.; hyoscine hydrobromide, 0.0033 mg.; phenobarbital (⅛ gr.), 8.1 mg.; and pepsin, NF, 150 mg. In the enteric-coated core: pancreatin, NF, 300 mg.; and bile salts, 150 mg.

A. H. ROBINS CO., INC.
RICHMOND 20, VA.

antispasmodic—sedative—digestant

Donnazyme®

ears ago. If I increase some es now, how should I go about nnouncing the increase?

A. Don't! Just set the day—e first of the month, say—and en start charging your new es. You may want to make an ception for patients currently nder treatment. That is, you ay want to charge them the old es until they have completed eir current series of visits. ut the new fees should apply oth to new patients and to new lnesses of old patients.

If anyone asks about the in-reased fees, just say "Yes, hey've gone up." You'll be sur-rised at the number of old pa-ients who'll say to you or your ecretary, "I wondered when ou were going to raise them!" After all, if you haven't changed our fees in nine years, you've eally suffered from inflation. Your purchasing power is way own from what it was in 1951.

Q. Many professional man-gement men recommend charg-ng everyone the same fee for he same service. But I've been sing a double standard that eems sensible to me. I charge a igher fee for patients who take private accommodations in the hospital, a lower fee for patients who take semiprivate. What objection is there to this?

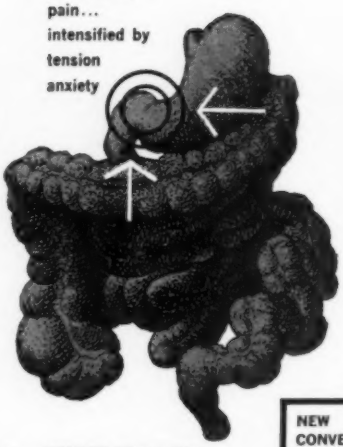
A. People often pick hospital accommodations for reasons that have nothing to do with their wealth. Just ask your hospital. You'll probably find that private-room patients may sometimes default on their hospital bills. It's better to decide on a fair fee for a given service, then to charge that fee in all cases except where there are special circumstances. Don't regard the nature of the hospital accommodations as a special circumstance.

Q. I've increased my fees recently, and I think they're fair now. But what should I say to someone who calls up and asks about the fee before being seen? What should my secretary say?

A. First, get them to come to the office. Your girl should say something like this: "I'm sorry, but it's impossible to tell what's involved without seeing you." Then offer them an appointment and bring them in. Above all, don't let the girl quote fees over the telephone. END

double trouble of the g.i. tract?

spasm
hyperacidity
pain...
intensified by
tension
anxiety



dual action in the therapeutic attack

ENARAX 10 provides
10 mg. oxyphencyclimine
the inherently
long-acting anticholinergic
plus 25 mg. ATARAX®†
the tranquilizer
that does not stimulate
gastric secretion

NEW
CONVENIENT
LOW DOSAGE
NOW AVAILABLE

ENARAX 5

Oxyphencyclimine HCl .....5 mg.
ATARAX (Hydroxyzine HCl) ...25 mg.

1 tablet twice daily
Supplied: Bottles of 60
scored white tablets.

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A SENTRY FOR THE G.I. TRACT

B.I.D.

Proven effective for continuous relief of both physical and emotional aspects of G.I. disease—hypermotility, hyperacidity, and hyperemotivity. One tablet b.i.d. provides 24-hour control of symptoms in peptic ulcer, gastritis, gastroenteritis, colitis, functional bowel syndrome, duodenitis, hiatus hernia (symptomatic), irritable bowel syndrome, pylorospasm, cardiospasm, biliary tract dysfunctions, and dysmenorrhea. ENARAX 10 has been successful in 92% of cases.[1,2] Let your G.I. patients profit from its dual, full-time therapeutic action.

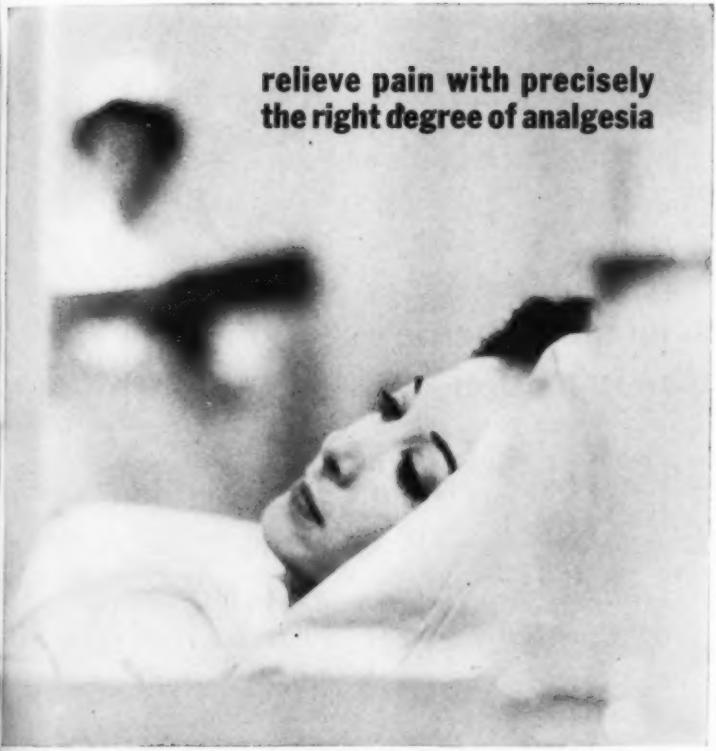
Dosage: One ENARAX 10 tablet twice daily — preferably in the morning and before retiring. The maintenance dose should be adjusted according to the therapeutic response. Use with caution in patients with prostatic hypertrophy and only with ophthalmological supervision in glaucoma. **Supplied:** In bottles of 60 black-and-white scored tablets. Prescription only.

References: 1. Hock, C. W.: Am. J. Gastroenterol. 34:293 (Sept.) 1960. 2. Leming, B. H., Jr.: Clin. Med. 6:423 (May) 1959. 3. Data in Roerig Medical Department files.

† brand of hydroxyzine

FOR HEMATOPOIETIC STIMULATION WHERE OCCULT BLEEDING IS PRESENT HEPTUNA® PLUS THE COMPLETE ANEMIA THERAPY

New York 17, N. Y.
Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being



control moderate to severe pain 'Empirin' Compound and 'Empirin' Compound with Codeine Phosphate products provide pinpoint control, anywhere along the pain scale, for all intensities up to that which requires morphine—**without narcotic excess.** For effective analgesic, antipyretic and antitussive action, prescribe the 'Empirin' Compound that suits your purpose best.

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Acetophenetidin	gr. 2½
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'EMPIRIN' COMPOUND* with CODEINE PHOSPHATE*

No. 1 — Codeine Phosphate	gr. ⅛
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*Subject to Federal Narcotic Regulations.

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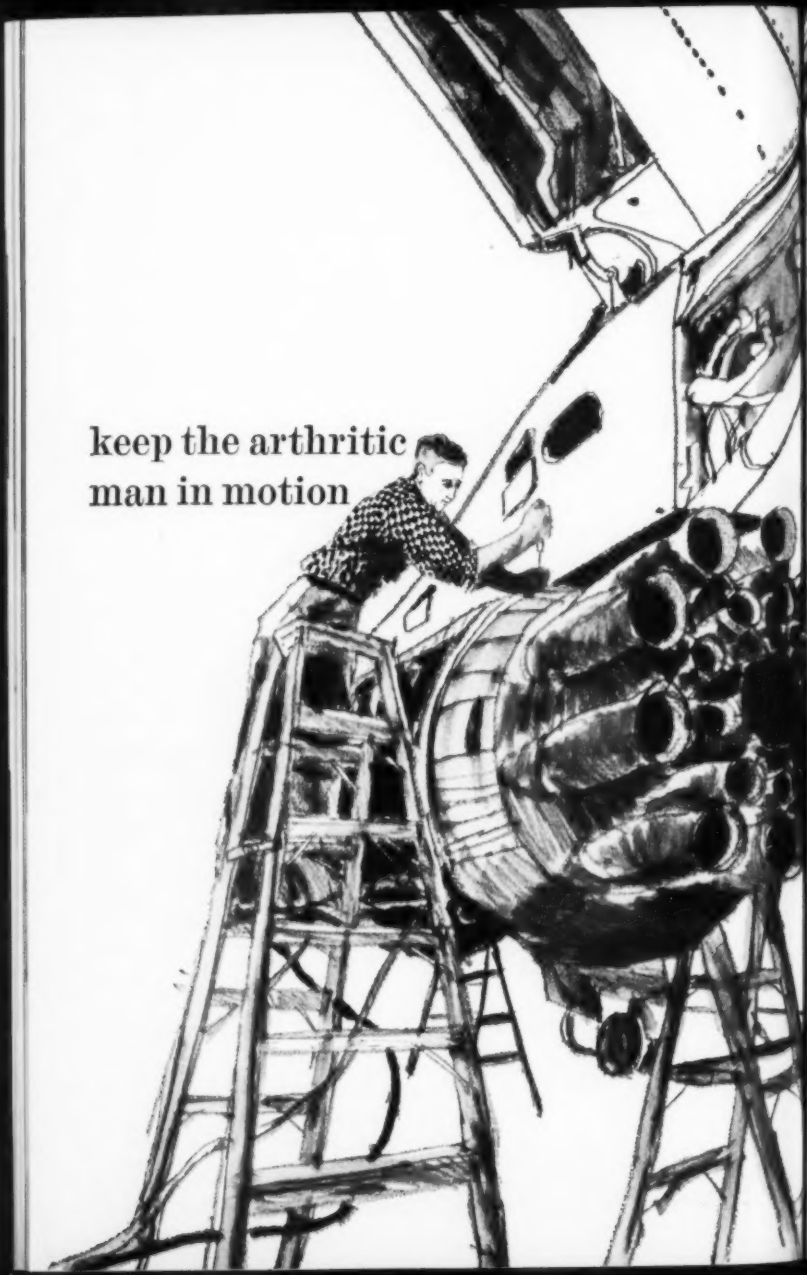

keep the arthritic
man in motion

Schering

th the first total anti-arthritic therapy

e than just anti-inflammatory therapy
e...DELENAR stops rheumatic inflamma-
with the more active corticosteroid,
ONIL...and DELENAR relaxes painful
le spasm with a proved muscle relaxant
d DELENAR quickly relieves motion-stop-
pain with better tolerated aluminum aspi-
for comfortable restoration of motion.[1,2]
you can restore motion safely, surely with
ENAR in *mild rheumatoid arthritis, early osteoarthritis, rheumatism, spondylitis, fibrositis, myositis, chronic fibromyositis.*

Formula:

DERONIL® (Dexamethasone) ..... lowest dosage anti-inflammatory steroid	0.15 mg.
Orphenadrine HCl ..... proved muscle relaxant	15 mg.
Aluminum Aspirin ..... fast analgesic relief of motion-stopping pain	375 mg.

t, E. M.: Pennsylvania M. J. *63*:708 (May) 1960. 2. Settel, E.: Clin. Med. *7*:1835 (Sept.) 1960.

prescribe

Delenar®

anti-inflammatory
relaxant
analgesic

H-353

Give your patient a wri

Yes, say many diagnostic clinics. They find it reassures the ill and the well, aids the profession, and pays its way

By

"This piece of paper is the best medicine any doctor's ever given me." The speaker (whom I'll call Harry Fenwick) was a heavy-set man in his forties, and the "piece of paper" he handed me was a report on his health. His story suggests something *you* can do to make *your* services worth more.

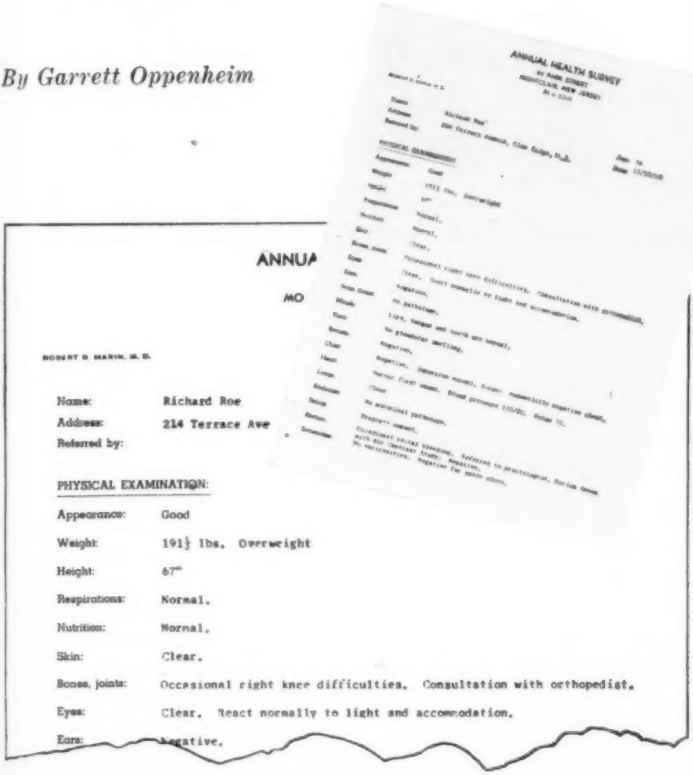
Five years ago, Fenwick consulted a G.P. about a nagging digestive ailment. Referred to an internist, he underwent a lengthy—and finally inconclusive—series of gastric tests and X-rays. According to Fenwick, the internist offered no clear-cut diagnosis, ended up prescribing a diet of farina. Fenwick ended up abandoning his diet *and* his doctors. But he gradually became sicker and more insecure. It wasn't until recently, when illness began to threaten his job, that he forced himself to take advantage of his company's free health check-up plan.

This time, Fenwick was impressed. Not that the examinations done at the Executive Health Center in Montclair, N.J., were so very different. But afterwards the director, Dr. Robert B. Marin, gave him two copies of a written report (one for Fenwick, and one for his doctor). What's more, Dr. Marin went over it with him item by item. The diagnosis: severe tension syndrome and overweight. The report made it unmistakably clear what he had to do to overcome the condition. The result for Harry

A m
singl
clini

t a written report?

By Garrett Oppenheim



ANNUAL HEALTH SURVEY

ROBERT D. MARIN, M. D.

Name: Richard Roe
Address: 214 Terrace Ave
Referred by:

PHYSICAL EXAMINATION:

Appearance:	Good
Weight:	191½ lbs. Overweight
Height:	67"
Respirations:	Normal.
Nutrition:	Normal.
Skin:	Clear.
Bones, joints:	Occasional right knee difficulties. Consultation with orthopedist.
Eyes:	Clear. React normally to light and accommodation.
Ears:	Negative.

A medical report that travels with the patient may save his life. A single-sheet form such as this one, used by a New Jersey check-up clinic, is easily prepared and can be reduced to credit-card size.

Robert Rehn, M.D.
ASHEVILLE, NORTH CAROLINA
P. O. BOX 208 ALPINE 4-4321

September 27, 1960

CONSULTANT
PREVENTIVE MEDICINE
OCCUPATIONAL HEALTH

Mr. John Smith
123 Main Street
Asheville, N.C.

Dear John:

The results of your annual health examination completed on September 23, 1960, revealed the following findings:

Height 72 inches, weight 210 pounds, blood pressure 170/110.

Visual screening shows adequate lenses and your audiogram reveals a moderate hearing loss which is similar to last year's audiogram. Physical examination reveals the large left hernia and hydrocele which should be corrected surgically. Rectal examination revealed internal hemorrhoids which also should be corrected. Varicose veins. [illegible] pattern—your overweight, elevated [illegible], high cholesterol value, etc.

John, all of the above indicates that it is high time you do something constructive about your general picture. I discussed this personally with Doctor Jones and he has agreed to handle the follow-up immediately. I am forwarding your chart today and suggest you get in touch with him as soon as possible. Let's not have any more excuses and let's get the ball rolling right away.

Best regards,

Robert Rehn, M.D.

Robert Rehn, M.D.

RR:bd

Fenwick: "My faith in doctors has been restored. My health has, too. I'm not worried about it any more."

Wasn't the piece of paper merely a symbol? Couldn't a conference have achieved the same result *without* the written report? Fenwick didn't think so: "It helped to have something I could take away with me—something in black and white. Only then could I be sure there was nothing to worry about."

The country's Harry Fenwicks are getting what they want from an increasing number of diagnostic centers. Not from all, however. So let's look first at the familiar argument *against* giving written reports to patients. This is summed up by Dr. Richard E. Winter, director of Executive Health Examiners in New York City.

Another way to give your patient a written report is to write him a letter. One advantage of this method over the printed form: It conveys a more personal feeling. Note the last paragraph of this example from Dr. Robert Rehm, who heads a diagnostic center in Asheville, N.C.

"The whole purpose of the written report," says Dr. Winter, "is to make the patient's medical history instantly available to the doctor treating him. To be accurate, it must be in scientific language. That means it's going to be pretty confusing to the average patient—and wide open to his misinterpretations. I think a medical report in the patient's hands can cause a lot of needless anxiety.

"You're not helping the patient when you give him a figure on his cholesterol that only a doctor can interpret. And it becomes even more ridiculous when you try to reduce all findings to laymen's language, as some diagnostic centers do. We go over our findings with the patient and then send the written report directly to his family physician. Of course, if the patient insists on having a copy of the report, we give it to him. But most patients never ask for it, and we don't encourage them to."

Dr. Winter's argument points up the possible drawbacks in giving written reports to patients. But these drawbacks are more theoretical than real, some other diagnostic services say. Declares Dr. Harry J. Johnson, director of Life Extension Examiners, New York: "We have given more than two and a half million written reports to patients, and

They're promoting a medical 'passport'

If the one-page report for patients is beginning to catch on, why not carry it to a logical conclusion? So asks a recently formed organization known as the Medical Passport Foundation, Inc. (35 E. 69 St., New York 21, N.Y.). It publishes a loose-leaf booklet about the size of a passport in which the patient's medical history can be kept up-to-date. The booklet works something like a savings account book: Diagnoses, treatments, and other medical data can be registered permanently in the manner of debits and credits. The M.D.-directed, nonprofit foundation sells the booklets to physicians at cost—$2.60 each—in batches of twenty-five or more. This charge is usually passed along to the patient, since the booklet becomes his property.

we have yet to find a reason to regret it."

Dr. Johnson and other proponents of giving written reports to patients say that private practitioners are beginning to adopt the idea—and that more should, for these reasons:

1. It dispels doubt. That's the biggest advantage, according to Dr. Johnson. "New patients regularly say to me, 'You're not keeping anything from me, are you?' Pointing to the report, I tell them: 'Everything we know about you is written there, and we'll back up every statement we've made.'"

2. It eliminates tricks of memory. With a written report kept up-to-date, according to Dr. Hilton S. Read, director of Atlantic City's Ventnor Diagnostic Center, your patient

never has to guess what procedures doctors have performed on him, or when. Dr. Johnson agrees, pointing out that patients are usually too distracted to remember details of an oral report. "Our written reports," he says, "are in nontechnical language, but they give patients all the findings: blood pressure, urine, X-ray results, even part of the ECG tracing. If we find anything positive, we ask the patient to take the report to his doctor. But if everything's normal, we urge him to hold on to it and have it available for emergencies." Many patients have the report photocopied and reduced to credit-card size and keep it in their wallets. The single-sheet, summarized

The case for discreet wording

"If you're going to give your patient a written report," says Internist Alfred P. Ingegno of Brooklyn, N.Y., "it should be as discreet as your oral report to him. It should have the same softness of terminology, the same considered way of saying things, the same stress on the positive. Such a carefully edited report, *plus a first-rate oral explanation,* makes good sense.

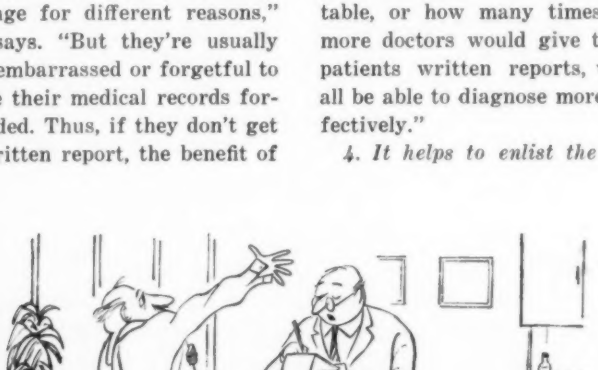
"But let's not deceive ourselves: Many a written report gives the patient the facts with no punches pulled. This kind of report can be emotional dynamite. I know one woman who suffered for years because she saw the written diagnosis of 'gastritis.' All of us are familiar with similar cases. Without discretion, a written report can become the patient's ticket to the psychoneurotic merry-go-round."

report lends itself well to this idea (see reproduction on page 68).

3. It helps the patient's next doctor. Dr. Johnson finds further support for giving the patient a written report in the way people change doctors. "They move, they marry, they change for different reasons," he says. "But they're usually too embarrassed or forgetful to have their medical records forwarded. Thus, if they don't get a written report, the benefit of those records can be lost forever."

Another doctor puts it this way: "While a good history is at least 50 per cent of the diagnosis, sometimes it's surprisingly hard to get. Many patients honestly don't know why they were put on the operating table, or how many times. If more doctors would give their patients written reports, we'd all be able to diagnose more effectively."

4. It helps to enlist the pa-



"I've done all I can. Why don't you see Schweitzer?"

tient's cooperation. Dr. Johnson speaks for many diagnostic centers when he says: "A check-up doesn't give full value without a written report to enlarge the patient's self-knowledge." Going a step further, Dr. Marin of Montclair's Executive Health Center finds the written report remarkably effective preventive medicine. Says he: "As a discussion piece for corrective action, it helps enlist the patient's fullest cooperation not only in getting well, but in staying well."

5. It guards against misinterpretations. Some critics say the patient is likely to misinterpret a written report. But doctors who use it maintain that the opposite is true—provided it's properly handled. It underscores what's important and de-emphasizes what isn't. Answering the frequently heard argument that a written report is apt to produce a neurotic reaction in the patient, Dr. Read has this to say: "It's actually one of the best safeguards against iatrogenic diseases that I know." However, he and all other supporters of this type of report stress the need to supplement it with an oral one.

6. It's an inexpensive added service. At this point, you may be asking yourself if giving written reports to patients isn't simply a fine bit of trim—all very well for large diagnostic centers with complete secretarial set-ups. But what about the busy private practitioner? Considering his time and effort, are all these extra reports economically feasible?

They are indeed, says Dr. Johnson. "Think of the written report as equivalent to one more procedure in the patient's check-up—such as a blood sugar. For this extra procedure, you can add a modest fee to your bill." Adds Dr. Read: "Patients are educated to the cost of secretarial work and won't complain if you explain the extra expense to them."

Many doctors who furnish written reports say that patients consider such reports as a worth-while return for a small investment. There's no doubt, these M.D.s feel, that it will enhance the value of your examination in the patient's

eyes. He gets something to take away with him, something to show for the examination.

If giving patients a written report is a good idea, what's the best form to use? How do you word the report? And is it ever advisable *not* to give the patient all the facts? Here are some answers that sum up the thinking of doctors favoring the procedure:

► Work out your own printed form along the lines of the one reproduced on page 67. Use it to record the patient's good health as well as his illnesses. Give one copy to the patient; keep one for your files.

► Alternatively, dictate a letter to the patient (see page 68) summarizing all technical data in simple language.

► If a malignancy is found, many doctors get in touch with the patient's family. These doctors refer to a malignancy in the report as a "mass" or "tumor" requiring immediate medical attention. But when the patient specifically asks if it's malignant, "we tell him," says one doctor. Another adds: "We've found that people who come to us for check-ups fear one thing more than they fear anything else, and that's being kept in the dark." END

Dining at the Ritz

A patient of mine was found dressed and ready to leave the hospital—without my knowledge—the day after he was admitted. He insisted that he couldn't possibly stay in a place that charged 60 cents for a glass of juice, $1.50 for a bowl of cereal, and $1.80 for a cup of coffee. Shaking with anger, he pointed to the listing he'd found on his breakfast tray: "Juice 60cc.; coffee 180cc.; cereal 150cc." —H. S. EMIL, M.D.

For each previously unpublished anecdote accepted, MEDICAL ECONOMICS *pays $25 to $40. Address: Anecdotes, Medical Economics, Inc., Oradell, N.J.*

Aid for your aide:

The care of a medical office

Your aide needn't be a drudge to keep your office neat and efficient. These tips, addressed to her, will help

By Horace Cotton

After all those dos and don'ts I saddled you with during my last visit on these pages, I'm back again with some more tips on another topic. It's the care of your own special domain—the doctor's office. It *is* your domain, too—inside and out. Have you ever really noticed, for example, that entrance door on the corridor? Does it need a coat of paint? And that lettering of your doctor's name and specialty on the glass panel. Has it seen happier days? A short note to the doctor as a gentle reminder ought to do the trick: "Front door shabby. May I call landlord and ask him to spruce it up?"

All of which leads to the first of three rules you'll want to use as a guide in all your office care:

1. Look at things freshly every day. However elaborate your check-up system, it won't work 100 per cent if you let your eye get used to things as they are. Suppose the sun has been fading those fine old framed color prints on the reception room

wall, and the effect is dingy. Chances are, you're so used to seeing the frame—in a vague way—that you no longer see the pictures. If it's true that you're the doctor's "eye," you'll want to keep that eye fresh.

Of course, it's only natural that office routine discourages this kind of alertness. At five minutes after nine, you open the windows (or set the thermostat), rearrange the magazines, throw out torn and tired copies,

A daily tour of inspection

Where to look	What to check
Outdoors	Paintwork, windows, yard, and shingle.
Reception room	Temperature, ventilation, lighting; floor and rugs; condition of furniture and fixtures; freshness of water in vases; cleanliness of walls, pictures, and ash trays; magazines; bulletin board.
Aide's work area	All applicable items above, plus: orderliness of cabinets, shelves, desk, and typewriter.
Consultation room	All applicable items above, plus: clean blotter, functioning desk pen, fresh drinking water, new medical journals, new memo pad, replenished stocks of tongue depressors, candies for child patients, etc.
Examination and treatment rooms, laboratory, toilets	All applicable items above, plus: dust-free walls, vents, cabinet tops, etc.; stain-free sinks, bowls, bottles, labels; full quota of supplies; fresh linen; deodorizer; clean waste receptacles.

Watch those laundry bills

If your office linen is rented, remember that your monthly payment entitles you to fresh, whole linens in the right sizes. Your rental service will soon learn whether you check deliveries carefully.

If the doctor uses his own linen, here are some musts:

- Mark everything plainly and indelibly in at least two places.
- Count everything carefully, going and coming.
- Keep a duplicate of your list.
- Inspect returned laundry carefully, and check bill.
- Repair minor damage promptly.

If you want to conserve your linen supplies, consider these practical tips:

- Cover pillowcases with towels instead of using a fresh pillowcase for each patient.
- Don't use sheets for patients who don't have to undress. Paper towels or rubber sheets will cover the table area just as well.
- For any patient coming regularly for a procedure that calls for a gown, tag one with his name (in his presence) and use it several times.

move some ash trays around, and open your appointment book. You're all set to prepare the examining rooms and get on with your bookkeeping and typing.

But you don't see what the patient sees when he walks in for the first time. If yours is like some of the many doctors' offices I've visited over the years, he may find the seating arrangement forbiddingly formal, with furniture lined up stiffly along the walls. The rug is tired, the floor around it dark with a mixture of dirt and old wax. The lamps certainly weren't designed to illuminate the periodical on a patient's knee. The flowers have gone limp, and the ash trays give

off a distinct back-room odor.

Probably the janitor is dragging his feet again, giving the place his customary lick and a promise. But you—not the doctor—should be riding herd on him. Even so, there are things you can do without taking over the janitor's function. How about selling the boss on a rearrangement of the seating—something less rigid? As for the rug, you can get permission to send it off for a shampoo. While it's gone, you can have the floor cleaned. High-wattage bulbs will improve inefficient lamps. The flowers? You can get fresh ones by phoning. And what the ash trays need—every day—is a good hot bath.

2. Develop a do-it-now approach to office care. One of the best aides I know says: "At home, I carry my housekeeping schedule in my head. A typical item is to keep the refrigerator door clean. Each time I see a smudge, I wipe the door off with a damp cloth. At the end of the week, even if it doesn't *look* dirty, I clean it thoroughly, because it's time for it to be dirty. I do the same to the stove and the washing machine. With my clean-as-you-go system, nothing ever gets *very* dirty. So my regular cleaning days don't exhaust me. I work the same way in the office."

She makes a good point: It isn't enough to schedule chores to be done at set intervals. In effect, that's seeing how long you dare leave a job before it clamors to be done. Her sensible system—keeping ahead of the due dates—does a lot to lighten the office work load.

Accompanying this article you'll find three work-saving check-lists. Refer to them whenever seemingly more important work threatens to take over your time.

3. Don't schedule office cares as a second job for yourself. It's a mistake to look on yourself as part medical assistant, part drudge. Weave office care into the fabric of your day. This takes planning, and here's a story to illustrate what I mean:

A hard-working, conscientious aide sank into the chair beside her doctor's desk one evening and said: "Doctor, I'm going to have to quit. I'm so tired

How to handle samples

The typical M.D. in private practice receives thousands of drug samples per year. Here's what an aide can do with them:

- When a new sample arrives, ask the doctor whether you're to keep it. Store those he wants in a special cabinet.
- Sort samples by category, i.e., antibiotics, sedatives, stimulants, etc. Keep each category in a labeled box.
- Give out samples on doctor's instructions only.
- Every month, burn date-expired samples. Don't throw them in the wastebasket.
- When a box is full, ask the doctor to let you dispose of half the contents. If he gives permission, deliver *personally* to the local hospital pharmacist. Don't give to a drugstore. If the hospital pharmacist doesn't want them, burn them.

every night that my husband insists I give up my job."

The doctor, concerned, decided to study his aide's job. After measuring distances, counting steps, and timing her every act, he analyzed the record. What he found was a lot of wasted time, needless travel, and duplicated effort. His solution: a revamping of the office routine and the purchase of some modern business equipment.

That was three years ago. He still has his conscientious aide, and she doesn't complain of tiredness any more.

When I asked him what had helped her most, he said: "We fixed things to give her frequent changes of pace. She used to divide her morning—before my arrival in the office—into two distinct periods. In the first, she did her cleaning. Next, she tackled the bookwork. By the time she got to the books, she was already tired. Come time

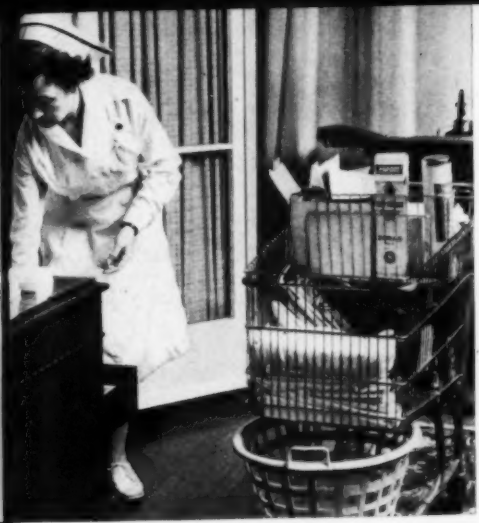
for patients, and she was bushed. At 5:30, she was *dead*.

"Obviously, her work sequence was all wrong. She'd tour the entire office with a dustcloth, then tour it again with supplies. Now she enters the examining room, dusts it, checks the linen, fills up on stationery, writes fresh labels, and all the rest of it, without leaving the room. She can do this easily, because I suggested that she start the day with a loaded shopping cart —which I bought. It holds all the supplies she might want on her rounds. I had a waste receptacle welded to it. Now, at the end of her tour, she returns unused supplies to storage and dumps the trash. It saves her a good ten trips per day."

I'm not saying you should organize *your* office care exactly the same way. Work out a system that suits you and your boss, after determining how many jobs you can do in *parallel* rather than in *series*. It may be true that no one can by taking thought add a cubit to his stature, but a little brain work can easily add an hour to your effective workday.

Supermarket technique saves steps for aide

This aide used to walk back and forth from storage closet to examining rooms to reception desk, lugging supplies. Now she saves ten trips a day by loading all into a shopping cart.



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Buy your next car abroad?

You can save money if you buy that foreign car in Europe. How much do you save? What about red tape? This man answers your questions, tells how easy it is

By James P. O'Neill

A "free" round-trip plane ticket, a gratis tour of the famous European road races, a pedigreed French poodle with each sale—almost every foreign car distributor has an enticing gimmick for luring you overseas to buy an auto. Actually, there's nothing free about these bonuses; their cost is hidden in the over-all price. As for the free airline tickets, you'll never be able to claim passage during the height of the travel season (April to August). You go at the convenience of the airline—when your number comes up on a long waiting list.

Despite such transparent sales techniques, however, more and more doctors *are* coming up with solid bargains in cars bought abroad during vacation trips. And it's getting easier to arrange. As one New York surgeon told me recently:

"Everyone is in the act these days. The Dutch airline KLM, for example, acts as agent for ShipSide, an Amsterdam firm specializing in selling cars to European visitors. The American Automobile Association now offers over 200 models of twenty-six foreign manufacturers at factory list prices. You can also buy a car directly from the manufacturer—or from your

New Jaguar heads for U.S. buyer from Port of New York.

local dealer. They'll all take care of every detail except getting your passport."

My surgeon-friend had learned all this while arranging his own car-buying vacation trip. He'd signed up with the World-Wide Agency of New York, Volkswagen's U.S. subsidiary, for a de luxe VW sedan to be delivered in Germany. The price he paid for the car was $1,185. Since the local American price for the same model Volkswagen was $1,610, he began his trip with a cash saving of $425. (Foreign car prices vary according to dealer, season, and scarcity of model. So you can expect local differences from prices quoted here.)

Arriving in Frankfurt, the surgeon went straight to the Volkswagen agency and found his new car ready for the road. It was complete with every document needed for European motoring—registration, licenses, insurance, and several others. Insurance is compulsory in most European countries; World-Wide had provided him with a policy covering damage ($50 deductible), fire, theft, un-

How much you save by buying abroad

	American price[1]
Alfa-Romeo Giuletta sprint coupe	3,838
Austin A-40 sedan (de luxe)	1,836
Austin-Healey 3000 roadster	3,371
Bentley Standard Saloon	16,475
Citroen DS19	3,245
DKW-Auto Union 1000 SP coupe	3,945
Fiat 1100 sedan	1,743
Jaguar Mark IX sedan	6,020
Mercedes-Benz 180 sedan	3,250
MG-A 1600 roadster	2,620
Peugeot 403 sedan (sliding roof)	2,304
Renault 5CV Dauphine	1,385
Rolls Royce Silver Cloud II sedan	16,775
Triumph TR-3 roadster	2,755
Volkswagen sedan	1,610

[1]The American price (F.O.B. New York City) may vary slightly according to dealer and scarcity of the model. You may be able to get small discounts on some of

American price[1]	European price[2]	Net savings
$ 3,838	$ 2,948	$ 890
1,836	1,717	119
3,371	2,715	656
16,475	12,559	3,916
3,245	2,636	609
3,945	3,022	923
1,743	1,611	132
6,020	4,301	1,719
3,250	2,634	616
2,620	2,227	393
2,304	2,028	278
1,385	1,248	157
16,775	12,899	3,876
2,755	2,345	410
1,610	1,518	92

the cars. Figures given here include tax and duty. [2]The European price (based on a package plan of Auto-Europe, Inc.) includes return freight, European port charges, marine insurance, U.S. customs tax and drive-away preparation as delivered to East Coast and Gulf ports. West Coast and Great Lakes ports slightly higher.

limited public liability, and property damage, etc. Cost of all documents including insurance: $55.50.

For the next thirty days, my friend drove his new car through most of Western Europe. Then he brought it back to the Frankfurt VW representative, who made all arrangements for shipping it to New York for a flat fee of $185. (Approximate shipping fee for Gulf ports, $155; Great Lakes, $230; Western ports, $255.) The surgeon paid $12 more for marine insurance.

Back in New York, he had to pay only two other items: a $10 wharfage fee and a United States customs tax of 8½ per cent of the car's value. "But since it was now a used car," he reports, "I was allowed a 30 per cent depreciation allowance on the original purchase price. This is routine for anyone picking up an auto in Europe." It meant that the surgeon retained over $90 of his original cash saving on the car. In addition, he'd been spared any car rental cost in Europe.

What about the standard $500 duty-free allowance for things the tourist buys abroad? My friend found you can't apply it to a car you arrange to buy before you leave the United States. You *can* apply it if you wait until you arrive in Europe to make your purchasing arrangements. Is this a good idea? Sometimes it is. But you should know about these drawbacks:

¶ If your European car doesn't have American specifications, you can't drive it legally in the United States. And unless you order them in advance, cars with such specifications are hard to find overseas.

¶ Even if you locate the car you want with American specifications, you'll probably find yourself on a waiting list. This could upset the timing of your vacation trip.

¶ Under American law, you can't sell the car you personally buy abroad for two years from the date of purchase.

¶ Finally, if you apply your $500 duty-free allowance to an automobile, you won't be able to take full advantage of other European bargains such as German cameras, French perfume,

and English woolens. The duty on these could be prohibitive.

In sum, you'll probably be better off buying from an American dealer for delivery abroad. If you have time, it won't hurt to shop around. As a test, I recently selected three cars and then checked their prices at various sales outlets. The most glaring discrepancy between two prices for the same model was a matter of $87. Though occasionally there'll be bigger differences, I'd be inclined to shop for convenience of servicing at least as much as for the lowest price.

What *kind* of car is it best to buy? This is only partly a matter of taste. The larger the car, the bigger your savings when you buy it abroad. The net saving on my surgeon's Volkswagen was $92. But if you buy a Citroen DS19, your net savings will be $609. On a Mercedes Benz 180 Sedan, you'll save $616; on a four-door Jaguar sedan, $1,719. And if you feel like splurging on a Rolls Royce Silver Cloud Saloon with electric windows and air conditioning, you'll save yourself a silvery $3,876.

Of course, you'll also save leasing or rental fees that could have cost you from $200 to $400 —plus the multiple headaches of using public transportation. END

Direct to consumer

Called to a slum tenement to treat an infant for generalized eczema, I prescribed goat's milk, instead of cow's milk. I knew the added cost would be a hardship on the parents, and as I left their tenement home, I wondered how in the world they would solve the problem. A week later, when I called again, I was literally staggered by their solution—as I walked in, I was met by two goats, tethered in the living room!

—JOSEPH R. DOLCE, M.D.

MEDICAL ECONOMICS' *Continuing Survey shows*

How the specialties co

In medicine, as in many other fields, specialism is now the prevailing way of life. Fully 55 per cent of all privately practicing physicians today are full-time specialists. A decade ago, only 37 per cent were. And the change is rooted in economic as well as professional reasons. Witness some pertinent findings from MEDICAL ECONOMICS' Continuing Survey:

The median net income of self-employed specialists from all types of medical practice in 1959 was $24,800 before taxes. That's 45 per cent more than it was in 1951. And it's 24 per cent more than the G.P.'s median earnings in 1959. The specialist outstripped the nonspecialist in other ways, too. Despite his generally higher fee schedule, the specialist collected a larger proportion of his 1959 billings. He kept both his expense ratio and his accounts receivable below the medians for G.P.s. And even after paying a higher Federal income tax, the typical specialist took home $3,900 more in 1959 than did the typical G.P.

Of course, the typical specialist exists only on paper. He's a statistical composite of thousands of practitioners in dozens of branches of medicine, each with its own distinguishing characteristics. To see how one specialty differs economically from another, let's examine nine large ones individually. The 1959 figures that follow are drawn from MEDICAL ECONOMICS' Continuing Survey. Those for earlier years come from this magazine's Quadrennial Surveys.

Dermatology: The typical

es compare financially

skin specialist can't complain about his 1959 net income from practice; he struck the exact midpoint for all specialists—$24,800. What lifts him out of the ordinary, economically speaking, is his earnings growth. Since 1955, his annual net from practice has increased a total of 52 per cent. Two factors contributing to this growth are a lower expense ratio (down seven percentage points in four years) and a higher collection ratio (up four points to 98 per cent). The dermatologist's collections are doubly impressive when you consider that little more than one-tenth of his receipts come from health plans. Give him credit, too, for the best accounts-receivable record among nine selected specialties: only three weeks' receipts outstanding.

Ear, nose, and throat: If anything distinguishes the ENT man economically, it's the fact that he's the most typical of all specialists. Both his 1959 net income from practice and his 1959 professional expenses missed the all-specialists medians by only 4 per cent. His collection ratio and his accounts receivable almost coincided with the medians for all specialists. And about the same percentage of his gross came from health plans.

General surgery: In 1959, for the first time in years, the surgeon's net income from practice rose to the level of the OB/gyn. man's ($27,900). Among typical doctors in nine selected special-

ties, only the orthopedic surgeon reported higher net earnings. Also noteworthy: The general surgeon's 1959 receipts from health plans amounted to 62 per cent of his gross. This set a new record for the nine specialties studied.

Internal medicine: Although the internist's net earnings still lag behind the median for all specialists, they've risen a sub-

Key financial data on nine selected specialties

Specialty	Net earnings from Practice	Professional expenses: In dollars	Professional expenses: As % of practice gross	Professional expenses: % of gross from health plans	Collect ratio	Value accour receivab (numbe nths' gros
Dermatology	$24,800	$11,700	31%	11%	98%	0.7
Ear, nose, throat	25,900	12,300	33	25	92	2.2
General surgery	27,900	12,300	31	62	91	3.0
Internal medicine	22,300	13,100	40	15	93	3.0
Obstetrics & gynecology	27,900	13,900	35	36	91	2.9
Ophthalmology	24,800	15,300	41	13	97	1.2
Orthopedic surgery	32,700	15,600	34	34	91	2.6
Pediatrics	20,700	12,800	40	8	92	2.8
Psychiatry	24,300	9,300	27	13	97	1.2
All specialties	24,800	12,800	35	24	93	2.2

All figures are medians for male, self-employed specialists. Accounts receivable are as of June, 1960; all other figures are for 1959. "Net earnings from practice" includes part-time salaries. "Total net from all sources" and "Total net after Federal income tax" include wives' income. Source: MEDICAL ECONOMICS' Continuing Survey.

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stantial 55 per cent in four years. That's a bigger gain than any other specialty recorded. Apparently the continued expansion of health insurance has finally made itself felt in this specialty; the typical internist now gets 15 per cent of his gross from the plans, as compared with only 5 per cent in 1955.

Obstetrics-gynecology: As previously mentioned, the obstetrician-gynecologist's 1959 net practice income was high enough to place him second, along with the general surgeon, among nine selected specialties. His earnings from health plans, as a percentage of gross, were 50 per cent higher than the median for all specialists, though they didn't come up to the figure for surgeons.

Ophthalmology: Economically speaking, the typical eye man is notable in two respects: He has the highest expense ratio and one of the best collection records (97 per cent of billings collected, with 1.2 months' gross outstanding). His 1959 net earnings coincide with the all-specialists median.

Orthopedic surgery: In 1959, the typical orthopedist netted more from medical practice than did any other type of specialist surveyed except the neurosurgeon and the plastic surgeon. Yet back in 1947, he was near

Collection ratio	Value of accounts receivable* (number of months' gross)	Total net from all sources	Total net after Federal income tax
98%	0.7	$26,000	$19,900
92	2.2	31,400	23,700
91	3.0	30,400	23,600
93	3.0	22,800	18,600
91	2.9	28,600	22,700
97	1.2	30,000	22,500
91	2.6	34,500	24,100
92	2.8	23,600	18,900
97	1.2	29,700	23,700
93	2.2	26,600	20,900

*Expressed as a multiple of current monthly gross income.

the very bottom of the income ladder.

Pediatrics: In 1959, the typical pediatrician's professional expenses stood 59 per cent higher than they did in 1955. (The median increase for all specialties was 40 per cent.) Partly as a result, the pediatrician's net from practice dipped below that of any other major specialty studied. It did, however, top the G.P.'s net by $700.

Psychiatry: The psychiatrist enjoys the lowest professional expenses (typically, $9,300) of any category of physician studied. As if to counterbalance this advantage, he sees fewer patients than do most of his colleagues. Even so, his 1959 net earnings came within $500 of the all-specialists median. Surprisingly, the typical psychiatrist now gets a larger percentage of his income from health plans than do the dermatologist and the pediatrician. And only 3 per cent of the psychiatrist's bills to patients go unpaid. END

"Of course you've been living in a shell—you're a nut!"

Can you name this doctor? He sings on the side

Possessor of a rich baritone voice, this 52-year-old physician turned down a contract with New York's famed Metropolitan Opera Company because he felt medicine was more important. Shortly after his graduation from Stanford University Medical School in 1935, he was auditioned by Edward Johnson, then general manager of the Met. "Until they offered me a contract, I wasn't sure which career I wanted," the doctor explains. "But then I knew it was medicine for me."

So he began practicing in Oakland, Calif. Soon he also began singing on the side. Over the years, he has sung twenty-two different roles with the San Francisco Opera Company, the Pacific Opera Company, and the Chamber Opera Company. Among his favorites are the title roles in "Falstaff" and "Rigoletto." He has appeared with such opera greats as Ezio Pinza, Lily Pons, and Tito Schipa. For the last ten years, he has concentrated on oratorio work, appearing as soloist in thirty-five performances of Handel's "Messiah."

How does he fit rehearsals and performances into a busy private practice? "It's easy," he claims. "I learned my repertoire years ago, while I was still in medical school. Now all I need is a couple of rehearsals with the cast or chorus, and we're ready to go. Most performances are in the evening, so they don't take much time away from my patients."

Who is this two-career man? Answer on page 123. END

How T-men can check you

When the Treasury doubts the income figure on a tax return, it investigates and recomputes the figure itself. How it does this may shock you

By Leonard Bailin, LL.B., C.P.A.

The Federal income tax return you'll be filing next month will almost inevitably be cross-checked a dozen different ways. Some of the Internal Revenue Service's cross-checks are simple. For instance, you report dividends received; companies report dividends paid you. The reports must match up—or else.

The more complex the cross-checks, the less you probably know about them—and the more you should. Consider the "net worth" method. The revenue men use it to reconstruct the income of a taxpayer if his own records of that income fall short. This major weapon is normally reserved for use against suspected tax cheats. But, like other weapons, it can also injure the innocent and the unwary. So for your own protection, you should know how it works.

It doesn't sound legal, but it is: The "net worth" method has been sanctioned many times by the courts. To illustrate how the method works, let's follow the case of Dr. Smith. The name is fictitious, but the facts are true. They're drawn from several different court cases.

Strangely enough, Dr.

THE AUTHOR *was formerly a member of the tax fraud unit of the Internal Revenue Service. Now he practices law in New York City. Mr. Bailin's article is drawn from material he gathered originally for the Journal of Taxation.*

eck your income

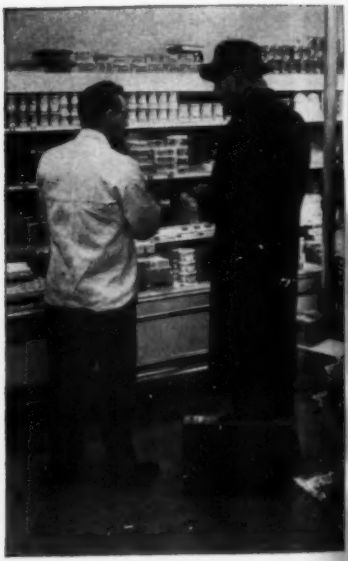
Smith's tax troubles began with a stroke of good luck. He won a car in a charity raffle. Not realizing that it was taxable income, the doctor failed to declare it. The omission was spotted during a routine cross-check by a revenue agent, and the doctor's tax return was singled out for a full audit.

Before the revenue agent visited Dr. Smith, he did a little preliminary visiting. He drove around the doctor's neighborhood and dropped in at a few local banks. He found that the doctor had a checking account at one of them. The agent asked for and received permission to look over his bank statements. They showed some large deposits and withdrawals—suspiciously large, since the doctor had declared an annual income of only about $15,000 in recent years. The agent made an appointment to see Dr. Smith.

The physician and his ac-

...Your taxes

Four steps



a tax agent's inquiry

If the I.R.S. assigns a special agent to investigate your income, there are four sources he's sure to check: area banks, to seek out hidden accounts or safe deposit boxes; local merchants, to get an idea of your living scale; the post office, to uncover addresses of brokers and stores you deal with; and your brokers, to inspect files of your stock transactions.

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Pro-Banthine, brand of propantheline bromide, is supplied in tablets of 15 mg. for oral administration in conditions such as peptic ulcer, gastritis, duodenitis, pylorospasm, biliary dyskinesia and spastic colon, and in ampuls of 30 mg. for intramuscular or intravenous administration in conditions such as ureteral spasm and pancreatitis in which prompt and vigorous effects are required or when nausea and vomiting preclude oral administration.

Usual adult dosage: One tablet four times daily. Up to four tablets may be administered four times daily for severe manifestations.

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1. Krantz, J. C., Jr., and Carr, C. J.: The Pharmacologic Principles of Medical Practice, Baltimore, The Williams & Wilkins Company, 1958, p. 843.

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Research in the Service of Medicine

countant were both present at the meeting. The agent assured them that the audit was "strictly routine." He checked the figures and the arithmetic on the doctor's return. He asked for verification of a few deductions. And he asked for the names of the doctor's bank and broker, along with a list of the major investments the doctor had made in the recent past.

After a few days, the agent concluded the audit. He didn't tell the doctor that anything was wrong, and he didn't ask for any adjustment in the doctor's return. But back in his office, the agent looked over his notes. The doctor's bank deposits were indeed high in relation to his reported income. More significant, the doctor seemed to be building up his savings and investments at an unusual clip. On the strength of those facts, the I.R.S. decided to launch a net-worth investigation of Dr. Smith. It wanted to find out the doctor's net worth on Jan. 1, 1954, his net worth on Dec. 31, 1959, and his total living expenses over the period between. With that information added to what it already had, the I.R.S. could calculate his income during those years.

A special agent trained in tax fraud investigations was now assigned to the case of Dr. Smith. First, this man checked with all commercial and savings banks in the doctor's area. His aim was to discover any unreported checking accounts, savings accounts, or safe deposit boxes in the doctor's name. He found two previously unknown savings accounts, one checking account, and one safe deposit box.

Next, the special agent reviewed the banks' microfilmed copies of all the doctor's canceled checks. After this review, the agent knew how Dr. Smith had spent every vacation—and how much he'd spent. He knew when Mrs. Smith's fur coat had been remodeled, what allowance the doctor had sent his son in college, what the doctor had paid for the carpet in his living room.

Soon the agent added new facts about the doctor's personal life. He visited every

Interesting Syndromes for Which Novahistine Expectorant Is Not Indicated

ADVERSIVE SYNDROME

(an experimental syndrome)

Consists of forced circling and compulsive movements and has been produced experimentally by sectioning fibers of the posterior longitudinal fasciculus, by ablation of Brodmann's area eight of one frontal lobe, by stimulating the red nucleus, by use of nitrogen mustards and in rats by a manganese-deficient diet. Condition similar to this has been produced in rabbits within a few minutes by intracarotid injection of diisopropyl fluorophosphate which apparently destroys cholinesterase and permits accumulation of excess acetylcholine in the cerebral tissues.

1. Encyclopedia of Medical Syndromes, Robert H. Durham, M.D. (2. Kennard, M., *et al.:* J. Neurophysiol. *4*:512, 1941. 3. Schiff, M., *et al.:* Arch. Otolaryng. *51*:672, 1950.)

number 15 *in the series*

storekeeper and grocer in the community to gather information about the doctor's scale of living and entertaining. He wrote to the local department stores to check on charge accounts and large purchases. Through the Post Office Department, he obtained a list of the return addresses on all mail re-

"He's got forty holes in him, and you, the coroner's physician, surmise that the wounds were not self-inflicted!"

nteresting Syndrome for Which Novahistine Expectorant Is Indicated

BRONCHITIS

"**bronchitis** (brong-ki'tis) [bronchus-itis]. Inflammation of the bronchial tubes." *Dorland's Illustrated Medical Dictionary*. Characterized by cough, congestion and inflammatory exudate.

Novahistine® Expectorant

Novahistine Expectorant combines the decongestant action of phenylephrine HCl and chlorprophenpyridamine with the liquefying action of glyceryl guaiacolate and the antitussive effect of codeine phosphate.

Each 5 cc. teaspoonful contains 10.0 mg. phenylephrine hydrochloride; 2.0 mg. chlorprophenpyridamine maleate; 10.0 mg. codeine phosphate (may be habit-forming); 100.0 mg. glyceryl guaiacolate; 13.5 mg. chloroform; 1.0 mg. l-menthol; alcohol 5%. *For adults:* 2 teaspoonfuls, every 3 or 4 hours. *For children:* 1 teaspoonful, every 3 or 4 hours.

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DIVISION OF ALLIED LABORATORIES, INC. • INDIANAPOLIS 6, INDIANA

Notable Success with VISTARIL...

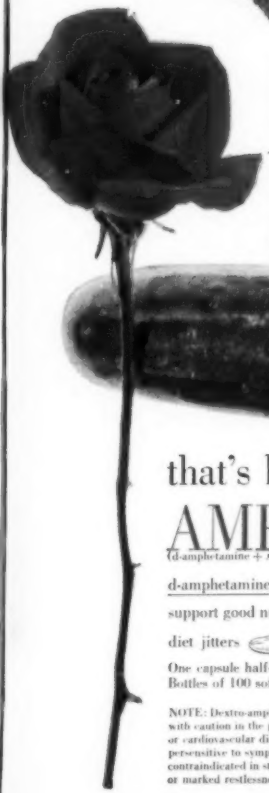
in prepartum tension and anxiety		allays anxiety without impairing ability to cooperate during labor and delivery[1]	reduces narcotic requirements and incidence of narcotic-induced respiratory depression, helps control emesis[1,4]
in the cardiac or the hypertensive patient		allays anxiety without adverse influence on blood pressure[2]	helps correct certain functional arrhythmias, does not increase gastric secretion[2]
in problem drinkers		allays anxiety — makes patient more manageable[3]	produces no significant depression of blood pressure, pulse rate, or respiration. No liver involvement reported
in preoperative tension and anxiety		allays anxiety without depression of vital functions[4]	reduces incidence of narcotic-induced respiratory depression and hypotension, relaxes skeletal muscle, smooths recovery and helps control emesis[4]
In pediatrics		allays tension in agitated, hyperkinetic patients	avoids danger of liver damage or other untoward reactions

References: **1.** Benson, C., and Benson, R. C.: Scientific Exhibit, Illinois Acad. Gen. Practice, Sept., 1960. **2.** Salmons, J. A.: Dis. Chest 38:105, 1960. **3.** Major, R. A.: GP 21:104, 1960. **4.** Grady, R. W., and Rich, A. L.: Scientific Exhibit, Am. Soc. Anesth., New York, Oct. 4-7, 1960.

ceived by Dr. Smith. One new charge account and two new brokerage accounts were thus discovered.

All brokers known to be doing business with Dr. Smith were visited; stock transactions were noted; business references were checked. While the special agent was engaged in doing all

shrinking like a violet



blooming like a rose

calm as a cucumber

that's how she's losing weight on AMPLUS® IMPROVED

(d-amphetamine + ATARAX® + vitamins and minerals)

d-amphetamine—keeps appetite down essential vitamins and minerals—support good nutrition the well-tolerated tranquilizer—Atarax®—reduces diet jitters Make the one for good measure AMPLUS IMPROVED.

One capsule half-hour before each meal.
Bottles of 100 soft, soluble capsules, this actual size. Prescription only.

NOTE: Dextro-amphetamine should be used with caution in the presence of hypertension or cardiovascular disease and in persons hypersensitive to sympathomimetic drugs. It is contraindicated in states of hyperexcitability or marked restlessness.

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Division, Chas. Pfizer & Co., Inc.
Science for the World's Well-Being®

®Brand of hydroxyzine

how does **Mellaril** *differ from other potent tranquilizers?*

Mellaril®

THIORIDAZINE HCl

specific, effective tranquilizer

provides highly effective tranquilization,
relieves anxiety, tension, nervousness,
but is virtually free of such toxic effects as

jaundice
Parkinsonism
blood dyscrasia
dermatitis

greater specificity of tranquilizing action results in fewer side effects

Virtual freedom of Mellaril from major toxic effects is due to greater specificity of tranquilizing action—divorced from such "diffuse" effects as anti-emetic action.

e most striking aspect of thioridazine [MELLARIL] therapy is the poverty side-effects."

conclusion it may be said that thioridazine is at least as effective in lieving psychiatric illness as other drugs of its class. On a milligram for illigram basis it has the same order of potency as chlorpromazine. In low incidence of side-effects and toxicity, it is superior to all other nquilizing drugs tested. For this reason it is well tolerated by patients, rticularly those who are not hospitalized and who frequently discontinue ir medication with other drugs because of dizziness, sleepiness, increased nsion, or Parkinsonism."[1]

ply: MELLARIL Tablets, 10 mg., 25 mg., 100 mg.

SANDOZ

[illegible], A Phenothiazine Drug in Treatment of Nervous Disorders, J.A.M.A. 176: [illegible], July 9, 1960

tool of research

RATTAIL HEAT TECHNIC

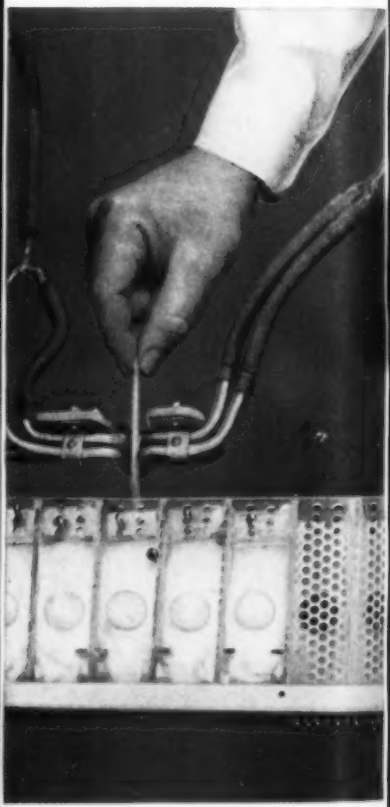
Twenty rats, in groups of four, are used in this modification of the method described by Davies *et al.*[1] The pain stimulus is provided by a heated resistance wire placed near the rats' tails. Direct contact with the hot wire is prevented by a specially designed water-cooled tail rest. Observers record the time interval that animals take to respond (tail jerk) to the heat stimulus.

Untreated rats react within three to six seconds. Any prolongation of this reaction time in animals receiving test medication is an indication of analgesia.

The rattail heat technic is one of many tests used by Lilly scientists to study the analgesic properties of compounds such as Darvon®.

1. Davies, O. L., Raventos, J., and Walpole, A. L.: Brit. J. Pharmacol., 1:255, 1946.

Darvon® (dextro propoxyphene hydrochloride, Lilly)



Rattail Heat Technic . . . valuable in preliminary screening of drugs for analgesic activity. Specially designed water-cooled tail rest prevents direct contact with hot wire.

■ "*. . . the substitution of propoxyphene [Darvon] for codeine provides a distinct advantage.*"

Gruber, C. M., Jr.: J.A.M.A., 164:966, 1957.

product of Lilly research

DARVON effective · safe · well tolerated

Darvon is a unique analgesic discovered and synthesized in the Lilly Research Laboratories. Milligram for milligram, Darvon is equal to codeine in intensity and duration of analgesic action yet has fewer side-effects.

Darvon is safe . . . Contraindications to Darvon have not been observed. Darvon does not produce adverse changes in the peripheral blood, liver function, kidney function, or clinical progress. Even after prolonged therapy, Darvon . . .

- does not cause physical dependence
- does not produce euphoria
- does not lose analgesic activity

Usual Dosage: 32 mg. every four hours or 65 mg. every six hours.
Darvon is available in 32 and 65-mg. Pulvules®.

120232

this, more information kept coming in the mail. The Treasury Department sent a list of the U.S. Government bonds bought by Dr. Smith. The state motor vehicle bureau sent a list of the cars he had registered during the period. The county clerk supplied a list of real estate transactions.

Among other liabilities, Dr. Smith had mortgages on his home and on his medical office. These turned out to be a gold mine of additional information. The doctor had filled out financial statements when he had got the loans, and these were opened to the investigator. All credit and personal references listed in them were checked.

Six months after the investigation had started, the special agent and the revenue agent met and added up the score against Dr. Smith. It seems the doctor's living expenses had just about equaled his reported income in every one of the years in question. Yet meanwhile his net worth had increased steadily, reaching more than $125,000 at the end of the period. There was one

Another Davol Exclusive

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DAVOL 3P*

ITEMS FOR

**Personal Patient Protection*

. . . a line of completely functional and labor-saving disposables involving mass daily routines

SAFETY: Assures patient safety by reducing danger of cross infection.

CONVENIENCE: Contains all necessary Items for catheterization of one patient. Can be stored easily where needed for immediate use.

ECONOMY: Eliminates autoclaving-and-labor expense of hospital-prepared sets.

Disposable Catheterization Set contains these sterile items:

New All-Purpose Rubber Catheter for use where 14 or 16 French is desired (optional) • Multi-Cupped Tray • Specimen Container • Lubricant • 8 Cotton Balls • Pickup Clip • Plastic Gloves • Plastic-Coated Towel • Plastic Cover

Disposable Prep Set contains:

Twin-Basin Tray • Razor (with blade) • 2 Absorbent Towels • Plastic-Coated Towel • 6 Cotton Balls • Plastic Cover

Now Available From Your Hospital Supply Dealer

missing link: the doctor's net worth at the start of 1954. The agents were unable to prove what it was. So they decided to see Dr. Smith again and let him hang himself.

And so he did.

The meeting was held at the Intelligence Unit of the local revenue office. Dr. Smith and his accountant were present, and so were the special agent, the revenue agent, and a stenographer. "We'd like to clear up a few things about your income tax return," said the special agent. "You don't have to answer any question you think might incriminate you, but we'd appreciate your voluntary cooperation."

"I've got nothing to hide," said the doctor, "I'll tell you anything you want to know."

The agent asked about the doctor's bank accounts, safe deposit boxes, brokerage accounts, bonds, and living expenses—all in an attempt to verify information the revenue service already had. The doctor answered the questions, not mentioning some of the assets the tax men already knew

IN SINUSITIS, COLDS AND UPPER RESPIRATORY DISORDERS

NEW DIMETAPP® Extentabs®

LET YOUR PATIENTS BREATHE EASIER!

In sinusitis, colds and other upper respiratory and allergic disorders new DIMETAPP Extentabs offer more useful decongestant therapy with minimum side effects.

UNSURPASSED RELIEF OF NASAL CONGESTION
In DIMETAPP Extentabs, the unexcelled antihistamine, Dimetane, and two outstanding decongestants—phenylephrine and phenylpropanolamine—promptly dry secretions and reduce edema and congestion in the nose, the sinuses, and the upper respiratory tract.

CLEAR BREATHING FOR 12 HOURS ON 1 TABLET
Long-acting DIMETAPP Extentabs offer up to 12-hour relief on just one tablet. Easier-to-use DIMETAPP Extentabs reach into areas nose drops or sprays can't touch—without rebound congestion.

EXCEPTIONAL FREEDOM FROM SIDE EFFECTS
DIMETAPP Extentabs are exceptionally free of side reactions. Dimetane offers a high percentage of relief with only drowsiness as a possible, infrequent side effect. Small, fully efficient dosages of decongestants minimize overstimulation.

DIMETAPP Extentabs contain Dimetane® (parabromdylamine [brompheniramine] maleate) 12 mg., phenylephrine HCl 15 mg., and phenylpropanolamine HCl 15 mg.

DOSAGE: Adults—1 Extentab q. 8-12 hours. Children over 6—1 Extentab q. 12 hours. Administer with caution to patients with cardiac or peripheral vascular diseases and hypertension, and to those sensitive to antihistamines. See package insert for further details and bibliography.

A. H. Robins Co., Inc. Richmond 20, Va.
Ethical Pharmaceuticals of Merit Since 1878

about, but naming a few that had not been uncovered.

"Have you received any substantial gifts of money or property during the last six or seven years?" asked the agent.

"No," answered Dr. Smith.

"Did you inherit any money during the period?"

"No."

"Did you have any large amounts of cash in your possession at the beginning of 1954?"

"No. I had spent all my ready cash on medical equipment when I opened my office the year before."

"During the years 1954 through 1959, did you have any source of income except your practice and investments?"

"No."

That tied the knot. The additional information the doctor had given verified what the agents had uncovered independently and helped them locate a few assets they had missed in their search. More important, the agents now knew that Dr. Smith didn't have any large cash hoard at the beginning of 1954 or any

A SAFE APPROACH

IN THE TREATMENT OF PSORIASIS

RIASOL

Clinically tested, safe and effective RIASOL offers maximum assurance against recurrence and adverse reactions.

RIASOL contains 0.45% Mercury chemically combined with soaps, 0.5% Phenol, and 0.75% Cresol. Available at pharmacies or direct in 4 and 8 fluid ounces. *Write for professional sample and literature.*

SHIELD *Laboratories*

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nontaxable income after that. So there was nothing that could explain away his rising net worth. As the agents now figured it, his net worth had increased from less than $20,000 on Jan. 1, 1954, to more than $130,000 by Dec. 31, 1959. Since all his reported income had gone for living expenses, the increase could only be unreported income.

Dr. Smith was told about the discrepancy and given a chance to explain it. He couldn't. So the doctor was indicted for tax fraud. At his trial, he pleaded guilty.

Dr. Smith undoubtedly deserved what he got: a jail sentence. But remember that the net-worth method can also be used against an innocent doctor who's merely *suspected* of tax fraud. Sometimes it's the only way the Government has to check the tax liability of a man whose records are inadequate. So keeping complete and accurate records is obviously your best defense against a net-worth investigation.

If you're investigated anyhow, here's what Dr. Smith's

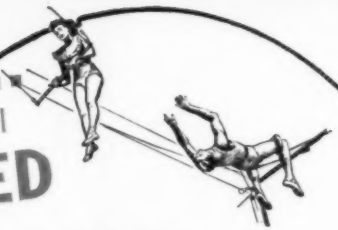
NOW...

also in Delightful

FLAVORED

FORM

Smooth-Working Combination

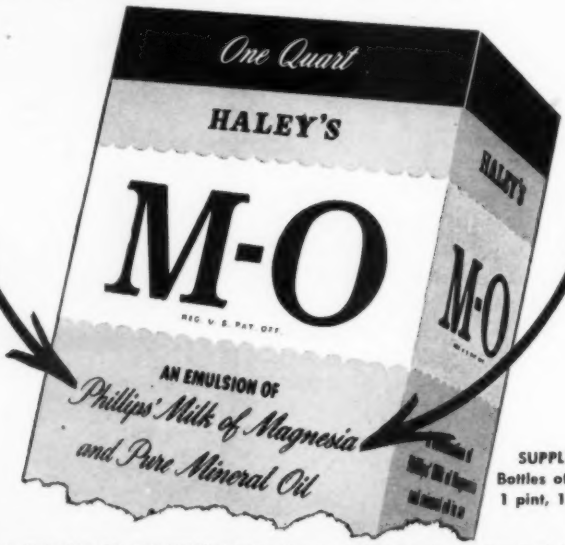


TO HELP CORRECT CONSTIPATION

Antacid • Laxative • Lubricant

Magnesium Hydroxide plus pure mineral oil make Haley's M-O a smooth working antacid-laxative-lubricant that efficaciously relieves constipation and the attendant gastric hyperacidity.

The oil globules in Haley's M-O are minutely subdivided to assure uniform distribution and thorough mixture with intestinal contents. Oil leakage is avoided and a comfortable evacuation is effected through stimulation of normal intestinal rhythm and blunted defecation reflex.



SUPPLIED: Bottles of 8 oz., 1 pint, 1 quart.

THE CHAS. H. PHILLIPS CO. DIVISION *of Sterling Drug Inc.* **1450 Broadway, New York 18, N. Y.**

bitter experience suggests that you should and should not do:

1. Cooperate with a *regular* revenue agent in a *routine* investigation. But once the investigation goes beyond routine (e.g., when a special agent appears on the scene), remember: You're not expected to cooperate yourself into serious trouble.

2. Don't appear at the intelligence office of the Internal Revenue Service without legal counsel. The Intelligence Unit's primary job is preparing tax fraud cases. Defense here is a job for an attorney, not an accountant or a taxpayer.

3. Don't volunteer information about your net worth. If you forget to name some assets that the I.R.S. knows about, you may open yourself to perjury charges. You'll fare better if you give no answer at all than if you give an incomplete or inaccurate one. END

Can you name this doctor?

The doctor pictured on page 93 is Henry A. Shefoff.

contain
upper
respiratory
infection

Tain

(Triacetyloleandomycin, Triaminic® and Calurin®)

inner
protection
with...

safe antibiosis

Triacetyloleandomycin, equivalent to oleandomycin 125 mg. This is the URI antibiotic, clinically effective against certain antibiotic-resistant organisms.

fast decongestion

Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

well-tolerated analgesia

Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. ℞ only. Remember, to contain the bacteria-prone cold ...TAIN.

DORSEY LABORATORIES • Lincoln, Nebraska
a division of The Wander Company

Dig these crazy tax deductions !

An aide's baby sitter, roses for maternity patients, an expedition to explore the arctic—these are only a few of the offbeat deductions M.D.s have been allowed

By A. Robert Ferguson

When an Illinois doctor broke his wrist watch not long ago, he listed half the repair bill as a Federal income tax deduction. "I couldn't run my practice without a watch," he explains. "It's just as necessary to my office routine as a typewriter or adding machine. So why shouldn't I deduct part of the cost as a professional expense?" The Internal Revenue Service accepted this line of reasoning without challenge.

Have *you* ever listed such an unorthodox deduction on your Federal tax return? Probably not. Only 447 of the 3,199 doctors queried in MEDICAL ECONOMICS' Continuing Survey say they have. Most of the rest indicate they're wary of taking any unusual deduction. One of them, an Indiana G.P., explains his attitude this way: "If you list unusual deductions, you're asking for trouble. You'll spend more time trying to explain them than they're worth. You can lose several days' work when a tax agent comes around for an audit."

Of course, if there's reasonable doubt about a deduction, you have every right to settle that doubt in your favor. Nobody owes more than the minimum tax the law requires. As

in a matter of minutes
"excellent" relief[4,10]
in skeletal muscle spasm with

Robaxin®
Injectable

Methocarbamol Robins U.S. Pat. No. 2770649

"... subjective relief of pain usually began within ten minutes..."[3]

"... a valuable therapeutic agent for the treatment of acute disorders involving skeletal muscle spasm."[4]

"... effective in producing immediate relaxation of paravertebral muscle spasm in patients who have undergone cervical and lumbar laminectomies."[9]

–and for continuing relief without drowsiness

Robaxin® Tablets
Methocarbamol Robins

"... a superior skeletal muscle relaxant in acute orthopedic conditions."

"An excellent result, after methocarbamol administration, was obtained in all patients with acute skeletal muscle spasm."[6]

"In no instance was there decrease in intensity of simple reflex responses or voluntary muscular strength."[7]

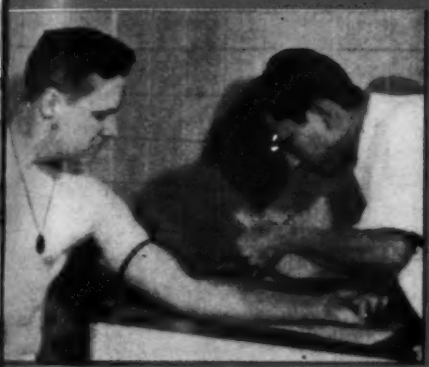
Ten published studies with 474 patients show ROBAXIN Injectable and ROBAXIN Tablets beneficial in 89% of cases.[1-10]

SUPPLY: ROBAXIN Injectable, 1.0 Gm. methocarbamol in 10-cc. ampul.
ROBAXIN Tablets, 0.5 Gm. (white, scored) in bottles of 50 and 500.

Also available, for oral use when severe pain accompanies skeletal muscle spasm
ROBAXISAL Tablets (Robaxin with Aspirin) in bottles of 100 and 500.
ROBAXISAL-PH (Robaxin with Phenaphen®) in bottles of 100 and 500.

A. H. ROBINS CO., INC., RICHMOND 20, VIRGINIA
Making today's medicines with integrity...seeking tomorrow's with persistence

Maximal bending before medication



ROBAXIN Injectable administered

Dramatic improvement 15 minutes later

Factual Clinical Data: Male patient with marked spasm of right lumbar region found even slight bending extremely painful. Fifteen minutes after administration of 10 cc. of ROBAXIN Injectable, spasm had disappeared and patient could bend without pain. Photographs used with permission of patient.

References:

1. Carpenter, E. B.: Southern M.J. 51:627, 1958. 2. Forsyth, H. F.: J.A.M.A. 167:163, 1958. 3. Grisolia, A., and Thomson, J. E. M.: Clin. Orthopaedics 13:299, 1959. 4. Leventen, E. O., and Vaccarino, F. P.: Current Therap. Res. 2:497, 1960. 5. Lewis, W. B.: California Med. 90:26, 1959. 6. O'Doherty, D. S., and Shields, C. D.: J.A.M.A. 167:150, 1958. 7. Park, H. W.: J.A.M.A. 167:168, 1958. 8. Plumb, C. S.: Journal-Lancet 78:531, 1958. 9. Poppen, J. L., and Flanagan, M. E.: J.A.M.A. 171:298, 1959. 10. Schaubel, H. J.: Orthopedics 1:274, 1959.

one tax authority puts it: "If a particular deduction has never been granted before, there's no way the Government can tell you in advance whether it's acceptable. The only way to find out is to claim it. The worst that's apt to happen is a subsequent bill for the unpaid tax on the disallowed deduction, plus 6 per cent interest."

Many doctors have apparently proceeded on this basis. They've tax-deducted some of the darnedest professional and personal expenses. Often, the deductions have been allowed *because the doctors have had good evidence to justify their claims.*

Many unusual deductions have been taken for practice-building expenses. A sampling:

A Louisiana physician was enthroned as a Mardi Gras king. It cost him a lot of money to wear the crown. This doctor listed the expenses on his tax return. He considered his deduction comparable to the Chamber of Commerce expenses that many doctors include on their returns. So did the I.R.S.; most of it was allowed.

An OB/gyn. man in Washington State buys roses for the mother of each baby he delivers. He's had no trouble listing the cost as a tax deduction.

A Michigan pediatrician buys wedding gifts for all his patients when they grow up and get married. Some day they'll have children of their own who'll need a doctor—and on these grounds the pediatrician has been able to justify his deduction.

A Virginia OB/gyn. man, like many doctors, enjoys his chats with associates and with an occasional patient in the hospital's coffee shop. Unlike most doctors, however, he successfully tax-deducts a dollar a week for the coffee he buys. It's a practice-building expense to him.

Some of the largest unorthodox deductions are listed as charitable contributions. Here are two examples:

A Mississippi M.D. gave a large sum of money toward the purchase of an elephant for his city's zoo. The I.R.S. never raised an eyebrow.

A Montana doctor once

JUST HOW GOOD IS THE TEENAGE DIET?

The facts are these: Many teenagers aren't getting anywhere near the Recommended Dietary Allowances of iron, calcium and certain vitamins.

Nutritional reform is an admirable objective. But what are your chances of making a planned dietary work with a willful teenager?

Clearly, preventive measures—in the form of dietary supplementation—often may be justified. And this is why new DAYTEENS™ will be of interest to the professional counselor.

Almost everyone agrees. The American teenager is the picture of health. His appetite, and enterprise, are enormous. And the feverishness of his daily activities can only point to an unfailing vitality. Or so it seems.

Yet the clinical facts are these: (1) THE NUMBER OF ADOLESCENTS WITH SUBOPTIMAL INTAKES OF MORE THAN ONE ESSENTIAL NUTRIENT IS APPRECIABLE. (2) CALCIUM INTAKE IS FRANKLY LOWER THAN DESIRABLE IN BOTH BOYS AND GIRLS. (3) SUBOPTIMAL INTAKE OF IRON IS PARTICULARLY PREVALENT AMONG TEENAGE GIRLS. (4) INTAKES OF ASCORBIC ACID AND B COMPLEX VITAMINS MAY ALSO FOLLOW A SIMILAR PATTERN.

These are conclusions which can be readily drawn from an increasing body of professional literature.*

The seriousness of the problem is underlined when we reflect that these dietary shortages occur at a time when *nutritional demands are perhaps greater than at any other period in the body's development.*

Certainly during this adolescent "growth spurt"—a time of striking skeletal and muscular changes—an increase in metabolic rate is to be expected. It is not surprising that the Recommended Dietary Allowances for calcium, iron, riboflavin, ascorbic acid and vitamin D are higher for adolescents than for adults. Yet, it is

*SEE DAYTEENS LITERATURE

®FILMTAB—FILM-SEALED TABLETS., ABBOTT

just at this age period—from 13 to 16—that the adolescent child shows greatest resistance to dietary correction.

The Teenager: He Likes What He Likes

The reasons are obvious to any professional observer. The teenager is his Own Man. He has outgrown the rules (or thinks he has). The subtleties of his rebellion are never more clearly evident than in his attitude toward nutrition. He has been told what, and when, to eat all his life. In his new mobility as a teenager, he is not at all unwilling to subvert the old disciplines. He eats what his friends eat, and his friends eat what they like. For many, the 4:00 soda-hour is all but inviolate.

Diets seen to be "grossly inadequate"

In the case of adolescent girls, impulsive dieting may lead to serious inadequacies of diet. Bowes[5] reported inadequate intakes of vitamin D and thiamine in both boys and girls during adolescence: *but teenage girls consumed lower levels of iron and calcium than children of either sex at any other age from four to 20.*

Similarly, Eppright and Roderuck[6], in a state-wide survey of Iowa school children, found dietary inadequacies of calcium and ascorbic acid for all children, and of iron for girls 12 and over. *But nearly half of the girls 15 and over showed a calcium intake of less than 67% of the Allowances.* Speaking of teenage girls in general, the authors concluded: "More than half had diets which would appear to be grossly inadequate."

And while outright deficiency symptoms are rarely seen among our teenage population, a prolonged dietary insufficiency in any adolescent may pose real problems during illness or stress.

The Alternatives

Such is the current status of teenage nutrition. What are the alternatives? An improvement in eating habits, certainly; and this would apply to practically all teenagers. Beyond this, and particularly in the case of the willful or indifferent teenager, a program of nutritional supplementation may be more than justified.

Such are the considerations which have led to the formulation and marketing of Dayteens,™ *a nutritional supplement designed expressly to help insure optimum nutrition in growing teenagers.*

The formula is shown below:

Each Dayteens Filmtab represents		Minimum Daily Requirement For Adults
Vitamin A (5000 units)	1.5 mg.	1.2 mg. (4000 units)
Vitamin D (1000 units)	25 mcg.	10 mcg. (400 units)
Thiamine Mononitrate (B_1)	2 mg.	1 mg.
Riboflavin (B_2)	2 mg.	1.2 mg.
Nicotinamide	20 mg.	10 mg.
Pyridoxine HCl	0.5 mg.	
Vitamin B_{12} (as cobalamin concentrate)	2 mcg.	
Calcium Pantothenate	5 mg.	
Ascorbic Acid (C)	50 mg.	30 mg.
Iron	10 mg.	10 mg.
Copper	0.15 mg.	
Iodine	0.1 mg.	
Manganese	0.05 mg.	
Magnesium	0.15 mg.	
Calcium	250 mg.	750 mg.
Phosphorus	193 mg.	

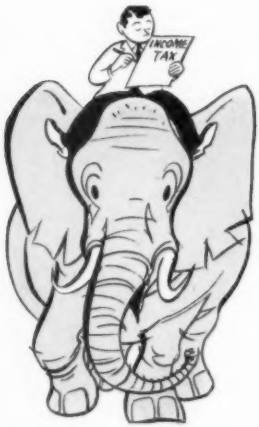
Note that the formula is well fortified with both iron and calcium—both important factors during adolescence, and both frequently seen to be deficient in the teenage diet. Another of the "essential" nutrients—ascorbic acid— is provided in one and one-half times the Minimum Daily Requirement. Indeed, the MDR's of all the essential vitamins are more than met (see above), and trace minerals are included for the role they play in normal body metabolism.

Filmtab®-coated to reduce size and assure stability, Dayteens takes a logical place among the other quality "Vitamins by Abbott." *If you'd like literature on Dayteens, which includes a detailed survey of the nutritional status of teenagers, see your Abbott man; or write to Abbott Laboratories, North Chicago, Ill.*

ABBOTT

101183

TM—DAYTEENS, ABBOTT'S VITAMIN-MINERAL SUPPLEMENT FOR GROWING TEENAGERS



claimed almost 30 per cent of his income as a church contribution. "The I.R.S. sure bucked," he says, "but I tore the appropriate page out of the tax regulations and sent it to them." He had checks to back up most of his $4,000 church contribution. But when his return was audited, $300 was disallowed. This represented his estimated (but undocumented) plate offerings.

Out-of-pocket losses have brought on some unusual deductions. A Missouri M.D. relates the story of his most bizarre business loss: "I'm a bachelor, and one of my female patients tried to put the bite on me by saying I gave her narcotics unnecessarily. The charges were false, but my attorney advised me to settle. So I felt justified in deducting the amount of the settlement on my tax return." The I.R.S. allowed the deduction to stand.

A Tennessee physician was examining a patient on a house call when a small Chihuahua took a liking to his almost-new $12 hat. The dog proceeded to chew it to shreds. The doctor listed the $12 as a tax deduction, and the I.R.S. accepted it

A Louisiana doctor scored in a strange way when his office was burglarized. The burglar didn't escape with any valuables, but he did break the doctor's examining chair. The doctor listed the repair bill as a

CYCLEX®

HYDRODIURIL® WITH MEPROBAMATE
HYDROCHLOROTHIAZIDE

for EDEMA...CYCLEX provides the prompt diuresis of HYDRODIURIL for rapid reduction of weight gain, breast fullness, abdominal congestion

relieve the symptoms of premenstrual tension

for MOOD-CHANGES...CYCLEX supplies the effective relief of meprobamate for nervousness, irritability, tension, nausea, malaise, insomnia

for GI DISTRESS...CYCLEX affords quick-acting relief of nausea and bloating associated with premenstrual tension

SUPPLIED: Tablets, bottles of 100. Each tablet contains 25 mg. of HYDRODIURIL (hydrochlorothiazide) and 200 mg. of meprobamate.

DOSAGE: Usual adult dosage is one tablet once or twice a day, beginning on the first morning of symptoms and continuing until the onset of menses. CYCLEX may be continued through the menstrual period.

Before prescribing or administering CYCLEX, the physician should consult detailed information on use accompanying package or available on request.

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MSD

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Division of Merck & Co., INC.
West Point, Pa.

BENADRYL Hydrochloride (diphenhydramine hydrochloride, Parke-Davis). Kapseals® of 50 mg.; Capsules of 25 mg.; Empleta® (enteric-coated tablets) of 50 mg.; in aqueous solutions: 1-cc. Ampoules, 50 mg. per cc.; 10- and 30-cc. Steri-Vials,® 10 mg. per cc. with 1:10,000 benzethonium chloride as a germicidal agent; Elixir, 10 mg. per 4 cc.; 2% Ointment (water-miscible base); Kapseals of 50 mg. BENADRYL HCl with 25 mg. ephedrine sulfate. INDICATIONS: Allergic diseases such as hay fever, allergic rhinitis, urticaria, angioedema, bronchial asthma, serum sickness, atopic dermatitis, contact dermatitis, gastrointestinal allergy, vasomotor rhinitis, physical allergies, and allergic transfusion reactions, also postoperative nausea and vomiting, motion sickness, parkinsonism, and quieting emotionally disturbed children. Parenteral administration is indicated where, in the judgment of the physician, prompt action is necessary and oral therapy would be inadequate. DOSAGE: Oral —adults, 25 to 50 mg. three or four times daily. Children, 1 or 2 teaspoonfuls of Elixir three or four times daily. Parenteral—10 to 50 mg. intravenously or deeply intramuscularly, not to exceed 400 mg. daily. High doses may be required in acute, generalized or chronic urticaria, allergic eczema, bronchial asthma, and status asthm
PRECAUTION: Avoid subcuta
perivascular injection. Single p
dosage greater than 100 mg. sh
avoided, particularly in hyperten
cardiac disease. Products cont
BENADRYL should be used cau
with hypnotics or other sedatives;
pine-like effects are undesirable; c
patient engages in activities re
alertness or rapid, accurate respons
as driving). Ointment or Cream
not be applied to extensively dam
weeping skin areas. Preparatio
taining ephedrine are subject
same contraindications appl
ephedrine alone.

Feb. 1961 (P-492)

when allergy looms large in the life of your patient...

relieves the symptoms of food allergy When the allergic patient can't resist eating an offending food, the ensuing punishment is often out of all proportion to the nature of the "crime." In such cases, BENADRYL provides a twofold therapeutic approach to the management of distressing symptoms.

antihistaminic action A potent histamine antagonist, BENADRYL breaks the cycle of allergic response, thereby relieving gastrointestinal upset, urticaria, edema, pruritus, and coryza.

antispasmodic action Because of its inherent atropine-like properties, BENADRYL affords concurrent relief of gastrointestinal spasm, abdominal pain, nausea, and vomiting.

PARKE-DAVIS

PARKE, DAVIS & COMPANY, Detroit 32, Michigan

BENADRYL®

antihistaminic-antispasmodic

cuts most allergens down to size!

casualty loss. The I.R.S. didn't challenge it.

Some doctors have listed unusual office and personnel deductions. For example:

A Florida physician claims the costs of planting and taking care of a large batch of rose bushes. Since he grows the roses primarily to get fresh flowers for his office, he considers them a logical tax deduction for office beautification. So do the T-men.

A Kentucky doctor has different ideas on how to make an office beautiful. He successfully deducted the taxidermist's fee

on an enormous stuffed fish for his reception-room wall.

An Indiana M.D. has seven small children. This means two sitters when he takes out his wife. "So I deduct the cost of one sitter as a business expense," he says. How is it justified? Quite simply. One of the girls answers the phone and notifies the doctor of any important calls from patients.

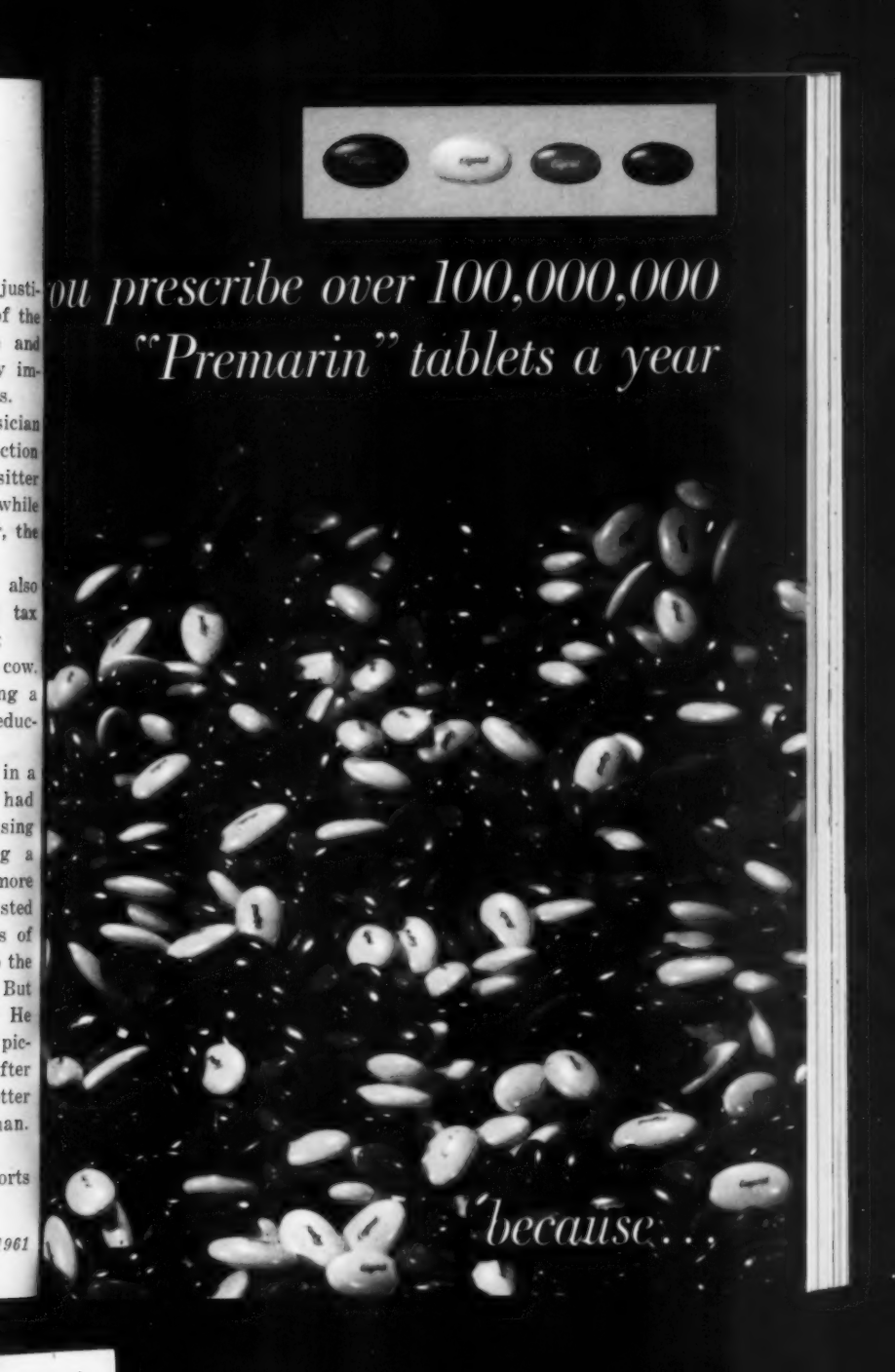
A Massachusetts physician takes his baby-sitter deduction a step further. He hires a sitter for his office girl's child while she works for him. So far, the T-men haven't balked.

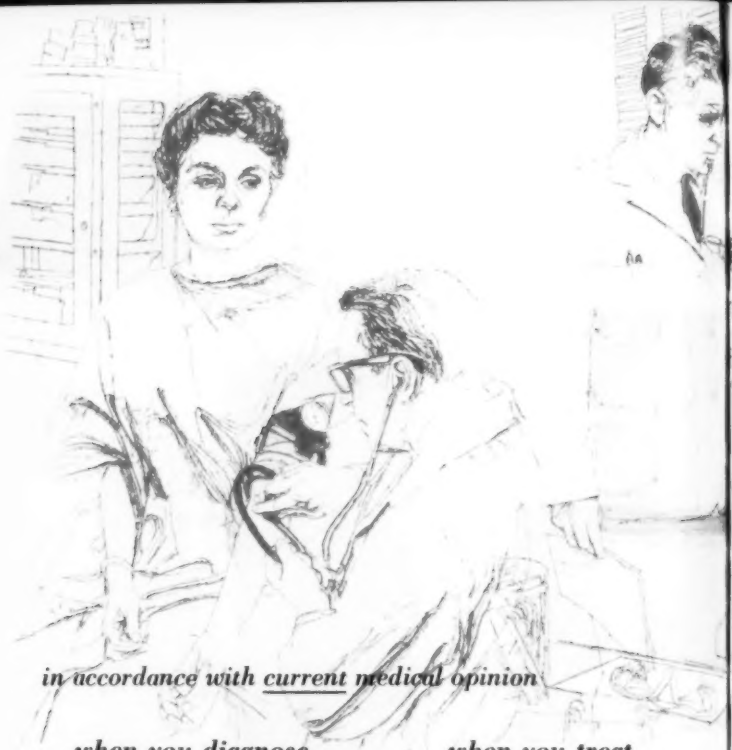
Personal casualty losses also account for some oddball tax deductions. Three of them:

A Florida G.P. owned a cow. The cow died while having a calf. Calf, doctor, and deduction are doing quite well.

A Colorado doctor lived in a community where "we had strict regulations against using sprinkling systems during a water shortage that lasted more than six weeks. When I listed an $800 deduction for loss of my trees and shrubs due to the drought, the I.R.S. balked." But the doctor didn't give up. He backed up his claim with pictures taken before and after the drought and with a letter from his local nurseryman. Eventually, it was allowed.

A Virginia doctor reports


ou prescribe over 100,000,000
"Premarin" tablets a year
because . . .



in accordance with current medical opinion

when you diagnose the menopause, you favor treatment

"I know that many physicians feel that the menopause is a physiological process and no therapy for it is indicated.... I do not belong to this school of thought, though therapy can certainly be overdone. We have to bear in mind, I think, that flushes are merely one aspect of the menopause; irascibility, migrainoid headaches, insomnia, apprehension, moods of depression and nervousness may occur without any hot flushes at all. Then we mustn't forget the sequelae of the menopause, such as senile vaginitis, pruritus vulvae, and osteoporosis. These must be considered part of the menopausal syndrome."*

when you treat the menopause, you favor estrogen therapy

"...the outstanding menopausal change is a sharp fall in the excretion of estrogens, generally followed by a rise in pituitary gonadotrophins. The logical treatment for this menopausal revolution in the hormone field seems to be substitution therapy, aiming at restoring, at least partly, the normal premenopausal hormone balance.... Androgens, sedatives and tranquilizers are all helpful in some ways, but none of them is anything like so efficacious as the estrogens."*

when you prescribe for the menopause, erapy you favor <u>natural</u> estrogens

pausal think most of us have agreed here
e excrat we would use natural estrogens
ollowedther than synthetic estrogens be-
rophinsuse of the likelihood of producing
s menotic effects with the synthetic com-
ne fieldunds."*
by, aim-e don't use stilbestrol because it
tly, thuses nausea in a certain number of
ne balople, we don't use ethinyl estradiol
es andty often because of headaches and
n somausea in occasional people and we
ythingefer conjugated estrogens in its
gens."*allest amounts . . ."*

in the menopause—there is no substitute for a specific

"Premarin"®

CONJUGATED ESTROGENS (EQUINE)

the <u>natural</u> oral estrogen that imparts a "sense of well-being"

Transatlantic Telephone Symposium, *The Effect of Estrogens in the Menopause*, Amsterdam/New York, 1959. Manuscript available on request. Published, J.M.A. Alabama 29:448 (May) 1960.

for 20 years
the leading natural oral estrogen fo
specific management of the menopaus

"Premarin"

CONJUGATED ESTROGENS (EQUINE)

provides the superior physiologic and metabolic benefits of natural oral estrogens presented as the complete equine estrogen complex

- assures prompt relief of menopausal distress
- imparts a gratifying "sense of well-being"
- exerts a protective influence in many vital processes, as in cardiovascular, bone and protein metabolism
- is well tolerated, convenient to take
- contains not just a single conjugate but all the components of the equine estrogen complex as they naturally occur (but recently appreciated is the important role that one of the lesser known conjugates, equilin sulfate, plays in the over-all activity of "Premarin")

Usual dosage:

1.25 mg. daily. Increase or decrease as required. Cyclic therapy is recommended (3 week regimen with 1 week rest period) to avoid continuous stimulation of breast and uterus.

Availability:

No. 865—Tablets of 2.5 mg. (purple), bottles of 20, 100, 1,000.
No. 866—Tablets of 1.25 mg. (yellow), bottles of 100, 1,000.
No. 867—Tablets of 0.625 mg. (red), bottles of 100, 1,000.
No. 868—Tablets of 0.3 mg. (green), bottles of 100, 1,000.
No. 869—Liquid, 0.625 mg./4 cc. (teaspoonful), bottles of 120 cc. (4 fluidounces).

AYERST LABORATORIES New York 16, N. Y. • Montreal, Canada

6112

that when several dogs he owned were killed by an automobile, he successfully claimed the loss as a tax deduction.

And here are two unusual deductions taken by an M.D.-musician and an M.D.-explorer:

A Washington physician successfully claims the cost of repairs for his musical instruments. Justification: He earns a sizable portion of his income from his sideline as a part-time musician.

A Missouri M.D. once tax-deducted over $3,000 for an arctic exploration trip. Justification: "I was gathering material for a new book in which I'd share in the royalties."

Many other doctors have taken big deductions for their own medical bills and traveling expenses for medical treatment. A Hawaii doctor claims the cost of his swimming pool as a medical expense. To justify such a deduction, you must prove that you, a dependent, or your patients use the pool as a prescribed medical treatment.

What do all these deductions have in common? The answer is *evidence*. The fact is, you're allowed to deduct practically anything as long as you have a sound reason for doing so, plus substantiation like canceled checks and receipts. That's what nearly all the doctors described in this article apparently had. Better not follow in their footsteps with anything less. END

In over five years

...for the tense and nervous patient

Despite the introduction in recent years of "new and different" tranquilizers, Miltown continues, quietly and steadfastly, to gain in acceptance. Meprobamate (Miltown) is prescribed by the medical profession more than any other tranquilizer in the world.

The reasons are not hard to find. Miltown is a ***known*** drug. Its few side effects have been fully reported. ***There are no surprises in store for either the patient or the physician.***

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Effective
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Outstandingly Safe

1. simple dosage schedule produces rapid, reliable tranquilization without unpredictable excitation
2. no cumulative effects, thus no need for difficult dosage readjustments
3. does not produce ataxia, change in appetite or libido
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5. does not impair mental efficiency or normal behavior

Miltown®
meprobamate (Wallace)

Usual dosage: One or two 400 mg. tablets t.i.d.
Supplied: 400 mg. scored tablets, 200 mg. sugar-coated tablets; or as MEPROTABS* — 400 mg. *unmarked*, coated tablets. *TRADE-MARK

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GM-2539

How to handle depreciation deductions this year

You may have to change your method of figuring them—and in some instances you'll have to deduct smaller amounts—as a result of a recent Supreme Court decision

By Sheldon Gorlick, LL.B.

The Supreme Court struck a hard blow at doctors' pocketbooks last June when it redefined "useful life" and "salvage value" for tax purposes. As a result, many physicians will be taking smaller deductions for depreciation of professional equipment on their current Federal income tax returns. For example, the typical physician has been writing off some $1,100 annually for professional auto expenses, most of it in depreciation. Under the new ruling, many physicians will lose several hundred dollars of this deduction. Here's why:

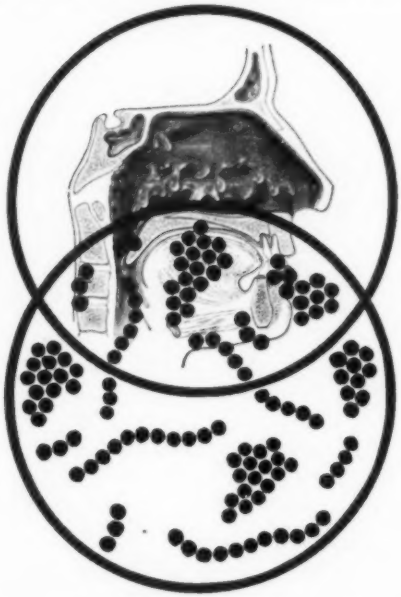
Until recently, you could base your depreciation allowance for a professional car on its cost basis minus its ultimate scrap value. You could do this even though you planned to sell or trade the car long before it became scrap. Then, assuming a useful life of, say, four years and electing one of the fast depreciation methods, you could deduct most of the original cost (less scrap value) from your taxable income over the course of two or three years. When you sold (not traded) the car, the difference between its sale price and its remaining net book value was taxable at the low capital-gains rate, not as

ordinary income. So you were many dollars ahead.

The recent Supreme Court decision has changed all this. "Useful life," for tax purposes, no longer means the actual mechanical-physical life of a car; it now means the length of time you expect to use the car in your practice. And "salvage value" no longer means the $50 or so you'd get for the car if you were to junk it at the end of its useful life. It now means the price you expect to get for it at the time you plan to sell or trade it.

Thus, if you plan to sell or trade a new professional car at the end of two years, you'll now have to regard two years—not four or five—as its useful life. Moreover, you can't depreciate the car below its estimated resale or trade-in value at the end of the two-year period; this means that, practically speaking, there can't be any sale pro-

when respiratory congestion is complicated by secondary bacterial invaders...



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Provides triple sulfas to control streptococcal, pneumococcal and staphylococcal invaders[4]

Each Trisulfaminic Tablet and each tsp. (5 ml.) of Trisulfaminic Suspension provides: Triaminic® 25 mg. and Trisulfapyrimidines, U.S.P. 500 mg.

Dosage: ***Adults***—2 to 4 tablets or tsp. initially, followed by 2 every 4 to 6 hours. ***Children 8 to 12***—2 tablets or tsp. initially, followed by 1 every 6 hours. ***Children under 8***—initially, ½ tsp. per 10 lbs. body weight, to a maximum dose of 2 tsp., then about ½ of this dose every 6 hours.

Medication may be continued until patient has been afebrile for 3 days.

1. Lhotka, F. M.: Illinois M. J. *113*:259 (Dec.) 1957. 2. Fabricant, N. D.: E.E.N.T. Monthly *37*:460 (July) 1958. 3. Farmer, D. F.: Clin. Med. *5*:1183 (Sept.) 1958. 4. Sophian, L. H., et al.: The Sulfapyrimidines, New York, Press of A. Colish, 1952, p. 132.

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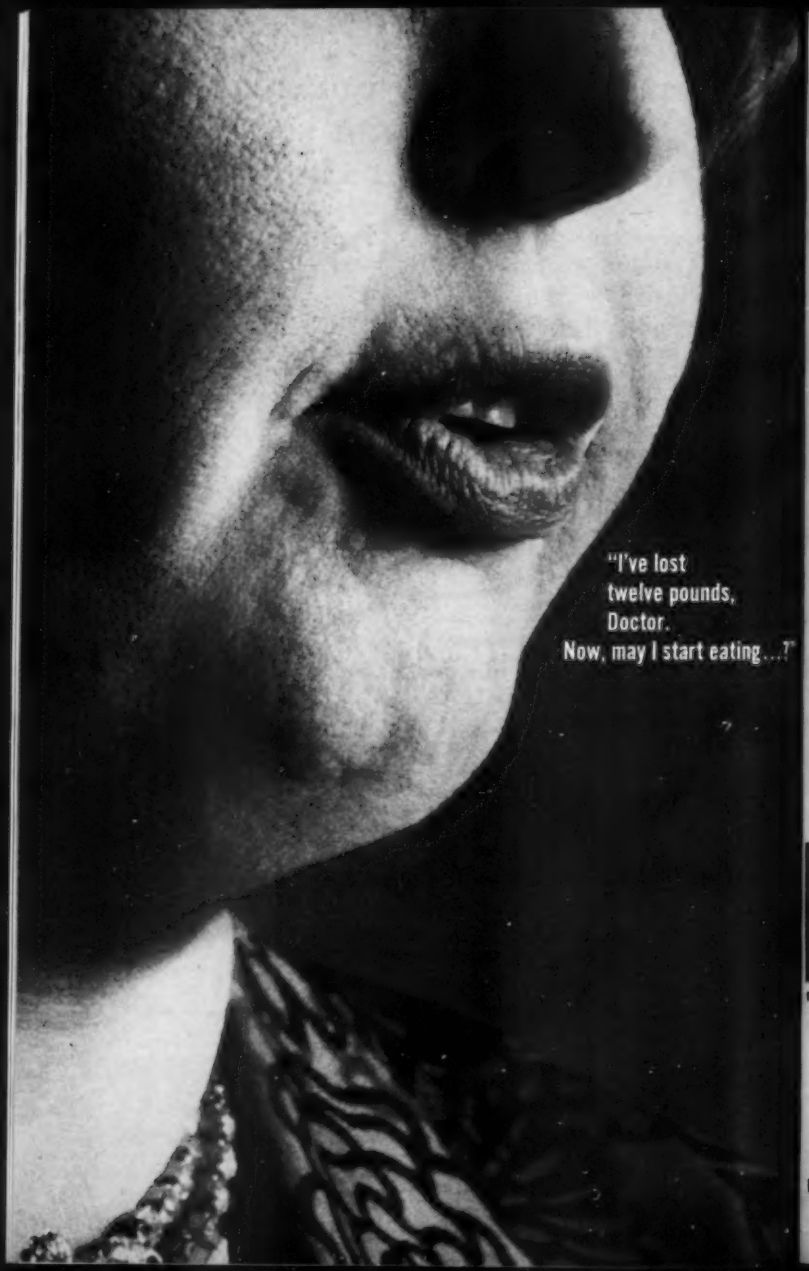
"I've lost
twelve pounds,
Doctor.
Now, may I start eating...?"

"crash diets" do not solve the basic patient problem: habitual overeating

In the treatment of chronic obesity, "fad diets" are not the answer. Your patients may suffer adverse somatic as well as psychic effects from alternating weight loss and gain. At the conclusion of a "crash-diet" program, the patient often falls back into familiar habits of overeating. The problem, therefore, remains the same.

The process of eliminating pounds in the chronically obese should be gradual. To accomplish this, obviously, new patterns of eating must be established.

BAMADEX tablets help the patient be satisfied on a diet which will cause him to lose weight. BAMADEX tablets combine two specific agents to overcome the habitual overeating in the chronically obese . . . the outstanding appetite suppressant, d-amphetamine, balanced with the tranquilizer, meprobamate. BAMADEX tablets help the recalcitrant patient keep within his prescribed caloric limits. It does this by curbing between-meal hunger, fatigue, nervousness, insomnia, and dizziness, which may lead to failure in diet reduction.

BAMADEX®

helps them to help themselves to less!

meprobamate with d-amphetamine sulfate Lederle

TABLETS

BAMADEX Tablets: *Each coated tablet (pink) contains: d-amphetamine sulfate, 5 mg.; meprobamate, 400 mg.* **dosage:** *1 tablet one-half to one hour before each meal. Higher dosage may be required in certain cases.* **precautions:** *Use with caution in patients hypersensitive to sympathomimetic compounds, who have coronary or cardiovascular disease, or who are severely hypertensive.* **supplied:** *Bottles of 100 and 1,000.*

Lederle

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fit to tax at the capital-gains rate. What's more, you're deprived of both of the fast depreciation methods—declining balance and sum-of-the-digits—on *any* asset you keep for less than three years, not just cars alone.

All this means smaller depreciation deductions, and therefore higher income taxes, for you as a doctor. So much is clear. But some aspects of the new rules aren't so clear. To shed more light on them, I've queried a number of tax consultants. Here are the questions I asked, together with a composite of their answers:

Q. Will a physician have to pay additional taxes for those past years in which he took depreciation deductions bigger than those now permitted?

A. It's unlikely unless his past returns are audited for some other reason. The Internal Revenue Service has enough to do without checking all returns for this one item.

Q. How should a doctor han-

"Well, do you have a prison that needs a good otolaryngologist?"

taste-tested by experts

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You will also be interested to know that Vi-Sol chewable vitamins have been reformulated. The new, improved formulations are authoritatively based, but practically modified to meet the needs of everyday practice. New Vi-Sol chewable vitamins provide safe, rational, practical levels of C, D and A for the growing child —preschool to adolescent.

10961

dle the depreciation of a car (or other depreciable asset) on his 1960 tax return if he plans to keep it less than three years but has, on previous returns, based his depreciation on a longer life?

A. The new rules are retroactive. This means he should either reduce or skip the depreciation deduction on his 1960 return so that his total depreciation deduction for any asset won't exceed the new allowable figure. For example, suppose he bought a $4,000 car for professional use late in 1958, and he plans to sell the car early in 1961 for $2,000. He can't deduct more than $2,000 in all ($1,000 for each year he owns the car) without exceeding the cost less the resale price. Suppose, though, that he has already deducted $1,950 on his 1958 and 1959 returns, using the declining-balance method. Then he can deduct a total of only $50 on his 1960 and 1961 returns combined.

Q. Now that the physician is required to estimate resale or trade-in value in advance, how should he go about it?

A. He can use his own past experience as a yardstick. If he's been getting about half of a car's original cost on a resale or trade after two years, he can assume he'll get the same proportion the next time. If there's any doubt, he can probably get a more accurate estimate from his dealer.

Q. What if the doctor eventually gets a bigger price from the sale of his old car than he originally estimated? Will he get the benefit of a capital-gains tax on the "profit"?

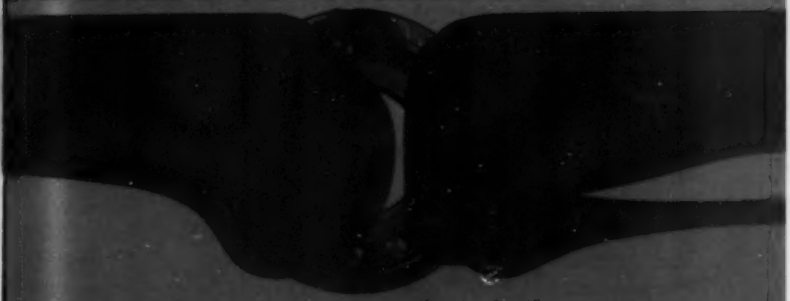
A. It looks that way. But if the actual resale price is only slightly higher than the estimated one, the tax saving will be negligible. If, on the other hand, the profit is considerable, the doctor may run into difficulties with the I.R.S.

Q. Will the recent Supreme Court decision affect the depreciation of other items that a doctor uses in his practice—books, furniture, and diagnostic equipment, for example?

A. In most cases, no. Professional items that have a useful life of less than one year are deductible, not depreciable. As-

Butazolidin
Geigy

n arthritis and allied disorders



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In virtually all forms of arthritic disorder, Butazolidin affords prompt symptomatic and objective improvement without development of tolerance . . . without danger of hypercortisonism.

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sets with useful lives of one to three years are subject to the same rules as the professional car the doctor keeps less than three years. But, since such assets as X-ray machines and examining tables are ordinarily used for more than three years, they can be depreciated by any of the three methods—straight-line, declining-balance, or sum-of-the-digits. The "salvage value" of long-lived assets should be estimated in the same way as the salvage value of a car.

Q. Does the new decision alter the rule allowing taxpayers to take a one-shot *additional* depreciation deduction in the year business property is first acquired?

A. No, that rule remains the same. It applies to either new or used "tangible personal business property" having a useful life of at least six years when acquired—office air conditioners, for example. In addition to your straight-line or accelerated depreciation allowance on such items, you can elect to deduct, in the first year of ownership, an extra 20 per cent of the cost—up to a maximum of $10,000—without adjusting for salvage. Thus, the limit of this deduction is $2,000 on an individual return. You can double that figure if you file a joint return. What's more, you get the full 20-per-cent first-year allowance regardless of what portion of the year you owned the property. (Your *regular* depreciation

tion allowance must be prorated for the exact length of time the property was owned.)

You can take this 20 per cent allowance only in the year of purchase. On the same year's return, you can also take a depreciation allowance for that year based on the remaining adjusted cost basis.

When you take the extra 20-per-cent first-year allowance, you must attach a statement to your return describing the property and showing the date purchased, how and from whom it was purchased, the useful life, the cost, and the portion of this cost to which the special deduction applies.

Keep in mind that the 20 per cent rule applies in every year that you buy qualifying property. So, if you're planning to buy two or more pieces of major equipment, you'll probably save by spacing your purchases over two or more years. END

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WEIGHT REDUCTION
A Realistic Approach

Perhaps the time has come for a thorough reappraisal of the overweight problem to find a more *reasonable* way to ensure a higher degree of success and a more enduring state of reduced weight for the patient.

A truly comprehensive weight reduction program for consideration

A good example of a comprehensive and highly effective program has been outlined by Barnes.[1] It is a four-point program, consisting of:

1. FOOD PLAN
2. EXERCISE
3. DOCTOR-PATIENT RELATIONSHIP
4. MEDICATION

FOOD PLAN

"The Food-Exchange System was used exclusively and explained to the patient using the illustrated pamphlet entitled, 'Meal Planning with Exchange Lists,' available through the American Dietetic Association. Since this plan gives a wide variety of food choices without calorie counting, most patients like it."

EXERCISE

"Increases in energy output, if physically possible, is a basic principle in weight reduction.[2] Each patient is advised to take a one-half hour walk twice a day. In addition, in the younger age group, muscle training exercises are prescribed. Improvement in posture is stressed for its cosmetic effects...."

DOCTOR-PATIENT RELATIONSHIP

"The role of the physician as counselor, advisor and friend cannot be overemphasized. The overweight patient needs the continuing support of his physician. During these regular visits, weight and general body measurements are recorded and a graph sheet of the patient's progress is kept up-to-date.... The encouragement and moral support through these regular follow-up visits must be underscored as probably the most important phase of a successful weight reduction program."

MEDICATION

"The purpose of any medication in a weight reduction program is to offset the symptoms so common following food withdrawal. These are anxiety, fatigue, depression, hunger, lack of energy and irritability. An effective anorexigenic agent should offset these symptoms in the majority of patients, and at the same time have a minimum of side reactions. Thus, if the agent is effective, the patient should be better able to consume a lower caloric intake and feel well at the same time. The medication selected for use and study...was Ambar."

There are no short cuts in treating overweight patients

Most short cuts are short lived. Recently, Feinstein[3] stated:

"Each new pill, injection, vibrator or menu finds its way to many physicians and patients who hopefully await some new approach which will avoid the failures of the old. The very novelty of the 'latest' preparation can arouse an enthusiasm in both physician and patient which then creates adherence to the dietary program...reasoning then attributes the successful performance to specific components of the new regimen rather than to its more effective feature: the enthusiasm which its novelty created. With time, many patients begin to lose their initial enthusiasm and can no longer tolerate the lack of sedation by food. They resume their former eating habits, the dietary program is said to have lost its effectiveness and it is cast aside as a failure."

When should weight control begin?

Attention has been drawn to the necessity of weight control in the early

stages of life. It has been noted that overweight children tend to become overweight adults more often than children of average weight.[4] The overweight child becomes the young man of 20 to 30 who may be only moderately overweight—10 to 30 pounds. His problem is no less important than the grossly overweight person approaching an age when cardiovascular implication must be considered. Comprehensive treatment is required in each age group, regardless of the degree of excess weight.

The Benefits of AMBAR™ in the Reducing Program

How has Ambar measured up in clinical studies?

In a double-blind portion of the Barnes study,[3] Ambar clearly distinguished itself as a valuable adjunct: *"Forty-one patients were studied and, of this number, 27 patients, or 65.8 per cent, averaged a loss of 1.36 lb. per week while taking Ambar. The same 27 patients lost 0.60 lb. per week while on placebo. Thus, 65.8 per cent of the patients studied on the double-blind technique lost 'more than twice as much weight per week while on the medication as on placebo."*

Subsequent results in 50 patients (not on double-blind method) were equally impressive:

"...during the period of observation from 4 to 32 weeks, 44 of the 50 patients lost a total of 800 lbs., or 18 lbs. per patient with a maximum of 65 lbs. in one patient. The average weight loss per week with these patients was 1.16 lb."

The study of Simkin and Wallace[5] goes beyond simple evaluation of Ambar in a weight reduction program. These investigators evaluated two factors: "(1) the relative roles of will power and anorexic drugs in promoting continued adherence to restricted diets, and (2) the role of the physician's personality in encouraging patients to 'stick to' their weight reduction program." One of their more fascinating findings regarding the role of will power is this: *"In the first 4 weeks of the double-blind study, the placebo patients lost weight almost as well as did the patients on the real medication [Ambar]. However, in succeeding weeks, the weight loss in the PLACEBO patients dropped off to 0.2 pound per week, compared to a steady loss of 1.0 pound per week by the REAL MEDICATION patients. These observations would imply that psychogenic impetus influences weight loss for about 4 weeks, after which it has no favorable influence on the results. It would seem equally clear that a proposed therapy or therapeutic agent must prove its effectiveness for more than 4 weeks if more than psychologic or placebo merit is to be ascribed to it."*

Of the conclusions and results of this study, the authors state:

"The value of a methamphetamine-phenobarbital anorexic agent (Ambar) was evaluated in 101 patients by the single-blind and double-blind method. The over-all loss of weight achieved by patients taking the active medication was significantly greater in both the double-blind and single-blind groups than that achieved by patients on placebo medication."

"The greatest effect of drug therapy was observed from the 5th to 16th week of therapy, after psychogenic influences had largely ceased to influence the degree of weight loss."

Patients on Ambar lost an average of 1.2 pound per week *throughout* the 16-week period.

Interesting and successful application of Ambar has also been made in 31 patients by Murray and Jessup[6] who concluded that Ambar "...provided acceptable appetite suppression without any side reactions....The blood pressure was carefully recorded at every visit, and no influence of the central nervous stimulant (methamphetamine) was observed; elevation of systolic blood pressure did not occur."

(please see following page)

When is an amphetamine not an amphetamine?

The advent of new fads is often compounded by the introduction of many "new" medications which are claimed to be unrelated to the amphetamine group of anorexics. In reviewing these drugs, Modell and Reader[7] added parenthetically: "...it is easy to demonstrate that all really belong to the same pharmacologic group of drugs as [amphetamine sulfate]." The same authors note that methamphetamine (the anorexic component in Ambar) exerts less action on the cardiovascular system than amphetamine.

The 900 calorie diet substitutes and Ambar

Ambar, when prescribed with the new complete diet substitutes, eases the psychic trauma inherent in such a drastic departure from established eating patterns, and helps keep the patient on his diet, even after the return to normal foods.

Sample plan for "personalized" administration:

Since the patient's response to sympathomimetic amines may vary, his medication should be adjusted accordingly. With Ambar, "personalized" adjustments are made easily. Here is one dosage schedule which may be suitable for many patients who require more methamphetamine as their weight control program progresses. (It does not suit all patients, of course, because all patients are not alike. For instance, if the patient has recently been taking anorexic agents, his medication plan may more logically begin with Ambar #2 Extentabs.)

One AMBAR #1 EXTENTAB *upon arising each morning.*

If dieting for every meal becomes more difficult, add one regular AMBAR TABLET *about 3 P.M.*

If the average weight loss in the second month is not essentially equal to that of the first month, change to one AMBAR #2 EXTENTAB *each morning.*

Seven reasons why Ambar should have a place in your weight reduction program

1. **Suppresses appetite effectively**
2. **Offsets the emotional symptoms of food withdrawal. An optimal methamphetamine-phenobarbital ratio allays anxiety, irritability, overexcitement, *as well as* fatigue, hunger, depression and lack of energy; encouraging a more favorable doctor-patient relationship**
3. **Cardiovascular side effects are minimal—even in hypertensives**
4. **Permits "personalized" therapy with 3 dosage strengths**
5. **Recommended for the moderately overweight (10-30 lbs.) and the "obesity-prone"**
6. **Added safety of smooth "Extentab" release—no jolts or sudden letdowns**
7. **Economical; available on Rx only**

DOSAGE AND SUPPLY: AMBAR #2 EXTENTABS: In each orange Extentab, methamphetamine hydrochloride 15 mg., phenobarbital 64.8 mg. (1 gr.)—one before breakfast. AMBAR #1 EXTENTABS: In each yellow Extentab, methamphetamine hydrochloride 10.0 mg., phenobarbital 64.8 mg. (1 gr.)—one before breakfast. AMBAR TABLETS: In each yellow tablet, methamphetamine hydrochloride 3.33 mg., phenobarbital 21.6 mg. (⅓ gr.)—one or two tablets before breakfast and lunch and in midafternoon.

PRECAUTIONS: While no increase in blood pressure has been reported, patients with cardiovascular disease should be under observation until their response to Ambar is established. Phenobarbital, in excessive and prolonged usage, may be habit forming.

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A. H. ROBINS CO., INC. RICHMOND, VA.

Financial briefs

Medical Economics, March 27, 1961

LIFE INSURANCE PREMIUMS hit you hard? You can arrange budget-sized monthly payments without incurring the usual high charges for this privilege. Most companies now offer a 3 per cent discount from regular monthly premiums through this "automatic check" plan: You authorize your insurer to draw a monthly check on your account. If your bank approves, you need never write another premium check.

"STOCK MARKET PROFITS for the Sophisticated Investor" is the name of a two-hour investment course now available on LP records. In it, New York Times financial writer Burton Crane tells you how to spot firms likely to boost annual earnings at least 12 per cent. You should find the $10 Am-Par album at your record shop.

IF YOU THINK YOU CAN'T FILE your tax forms on time, ask your district I.R.S. director for an extension of the April 17 deadline. He'll probably grant it if data you need are temporarily unavailable, if your tax adviser is ill, or if there aren't enough tax consultants in your area to handle the work. But you'll still have to pay interest at a rate of 6 per cent a year for every day you're late.

YOUR PATIENTS' INCOME AND SAVINGS are probably up from a year ago, despite the recession. Commerce Department figures for January show a

2 1/2 per cent rise in personal income compared with January, 1960. Much of the increase came from added unemployment compensation payments and other government benefits. At the same time, savings have shown a strong upward trend.

WHEN YOU COMPUTE your state gasoline tax for your 1960 Federal return, you may find this yardstick helpful: The typical physician drives 17,000 miles a year, according to a survey by this magazine. Divide 17,000 by the number of miles you get to the gallon; multiply by the per-gallon tax in your state; and then compare the result with your figure.

YOU CAN SAVE 10 to 20 per cent on auto insurance if you insist that the teen-age drivers in your family take a driver-education course. Over two-thirds of the nation's high schools now offer such instruction free. If your youngster's school doesn't, you can send him to a commercial course for about $70.

IF YOU RUN A RESEARCH FOUNDATION, are your donations to it tax-deductible? Not unless you keep the foundation's affairs separate from your practice. The Tax Court recently turned down a doctor's $7,550 deduction for gifts to his own vascular research foundation because it operated next door to his office and may have helped him economically.

How to invite a lawsuit: testify without counsel

Beware the friendly attorney who wants your side of the story in a lawsuit that's "only against the hospital, not against you."

DR. A. REYNOLDS CRANE
Statement or boomerang?

You may find yourself a defendant in the very same suit. That's the opinion of Dr. A. Reynolds Crane, chairman of the medicolegal committee of the Philadelphia County Medical Society and one of the top malpractice authorities in Pennsylvania.

Consider what happened in Philadelphia recently: A hospital was sued after a patient had been injured in an operating room accident. No M.D.s were named in the suit—at first. Later, the plaintiff's attorney took the sworn written statements of a number of physicians who agreed to make such depositions without consulting a lawyer. It wasn't long before the doctors who had made the statements under oath were included as defendants in the lawsuit—presumably on the basis of what they'd written in these statements.

Dr. Crane goes on to say that no one knew if the plaintiff's attorney delayed naming the physicians as defendants in the original suit "in order to catch them off guard without advice of counsel." Nor is such a motive implied. "We don't even know," he adds, "if the doctors' written statements revealed things that could be used against them. The fact is they were so charged only after they'd voluntarily made sworn

in hematoma

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spares your patient a lengthy and troublesome recovery

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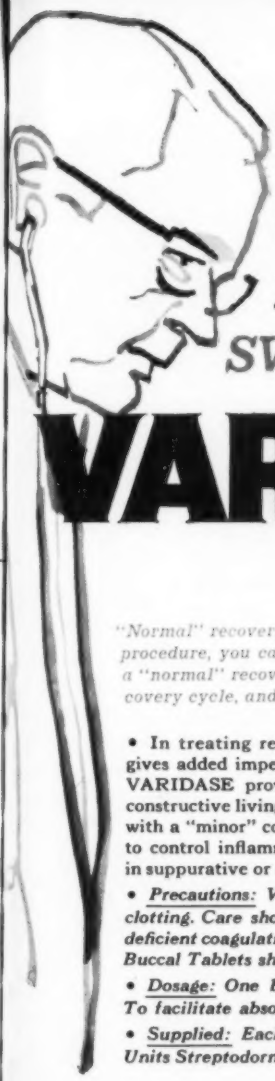
statements in a lawsuit in which they were not defendants."

It's beside the point, he adds, that in this particular case the doctor-defendants were later cleared of any charges of wrongdoing. "My point is," says Dr. Crane, "that in other cases of this kind, the plaintiffs' attorneys may resort to this practice for the sole purpose of building an otherwise unwarranted malpractice case against a physician... The physician untrained in the law is not always able to avoid testifying in a manner that might unwittingly make him appear liable for malpractice when no such liability actually exists."

How, then, can you protect yourself? Advises Dr. Crane: "Consult your own attorney and insurance carrier before testifying either in court or by deposition in cases you have been connected with, however remotely." END



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• *Precautions: VARIDASE has no adverse effect on normal blood clotting. Care should be taken in patients on anticoagulants or with a deficient coagulation mechanism. When infection is present, VARIDASE Buccal Tablets should be given in conjunction with antibiotics.*

• *Dosage: One buccal tablet four times daily usually for five days. To facilitate absorption, patient should delay swallowing saliva.*

• *Supplied: Each tablet contains 10,000 Units Streptokinase, 2,500 Units Streptodornase. Boxes of 24 and 100 Tablets.*

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Triaminic®, 25 mg., three active components stop running noses. Relief starts in minutes, lasts for hours.

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Calurin®, calcium acetylsalicylate carbamide equivalent to aspirin 300 mg. This is the freely-soluble calcium aspirin that minimizes local irritation, chemical erosion, gastric damage. High, fast blood levels.

TAIN brings quick, symptomatic relief of the common cold (malaise, headache, muscular cramps, aches and pains) especially when susceptible organisms are likely to cause secondary infection. Usual adult dose is 2 Inlay-Tabs, q.i.d. In bottles of 50. Rx only. Remember, to contain the bacteria-prone cold...TAIN.

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Don't lose control of your future!

Government, hospitals, labor, and the public are the four forces threatening to make medicine a controlled trade instead of a free profession. Here's what doctors are doing about it—and what they could be doing

By William Alan Richardson

I was talking recently with an internist I know. He's competent, successful, dedicated—and apprehensive.

"I've developed professional claustrophobia," he said. "Things are closing in on me. I'm pushed around by forces I can't control. And I don't know what I can do about it.

"Man is supposed to be master of his own fate. But not *this* man. Today I'm just a log, swept along with countless other logs by the racing current of socialism."

His fear is understandable. With our Government now committed to hospital care of the aged through Social Security, medicine's switch from private enterprise to public utility comes a giant step closer to reality.

Four forces are now advancing on the private physician: the Government, the hospital, the labor union, and the public. What can he do about them?

Look at the *Government* threat first: John F. Kennedy squeezed through the White House door on his promise of a "New Frontier"—a hot-rod model of the 1932 New Deal. No sooner had the new President taken office than he ordered legislation reintroduced to pay

President Kennedy insists his health-care-for-the-aged plan is "entirely in accordance with the traditional American system."

most of the hospital and nursing bills of some 14,000,000 Social Security beneficiaries.

Mr. Kennedy *could*, of course, use the A.M.A.-supported Kerr-Mills Act, passed by Congress last August, to help the aged meet their medical costs. But let's face it: The Kerr-Mills Act simply isn't compatible with the New Frontier. Meanwhile, this sober prediction: Once Social Security-paid health care for the elderly starts to roll, the age limits will go down, the benefits will go up, and we'll see a whole new spiral of Government in medicine.

Can the growth of tax-paid medical care be inhibited? I think it can. But first let's see what private medicine is up against:

Half of all American families now earn less than $5,400 a year. The Government-medicine pleaders say most of these people are medically indigent—i.e., they can afford most necessities but not a major medical expense.

Even if the other half of American families are *not* medically indigent, many of them *think* they are. They're scared stiff of getting sick. They figure that someone ought to do something to help them meet medical bills. And that "someone" somehow turns out to be Uncle Sam.

Given the chance, Joe Doaks will take to Government health insurance as a duck takes to water. And he won't give a thought to the cost. Even if he does, he'll conclude that he's

The principle that makes

produces soft, normal stools in functional constipation

SURFAK®

Water doesn't roll off this duck's back . . . because the water is Surfak-treated. Surfak decreases interfacial tension between water and oil . . . penetrates the natural oils in the feathers, permits water absorption, adding weight so that the duck sinks.

Similarly, in functional constipation, Surfak quickly permeates the heterogeneous fecal mass. The superior surfactant action of calcium bis-(dioctyl sulfosuccinate) reduces the interfacial tension between the aqueous and lipoid phases of the intestinal content to minimal values. The result is soft homogeneous feces which are easily moved to evacuation, naturally.

DOSAGE:

Adults: One 240 mg. Surfak capsule daily. *Children* (and adults with minimal needs): One to three 50 mg. Surfak capsules daily.

SUPPLIED:

240 mg. Surfak capsules in bottles of 15 and 100.

50 mg. Surfak capsules in bottles of 30 and 100.

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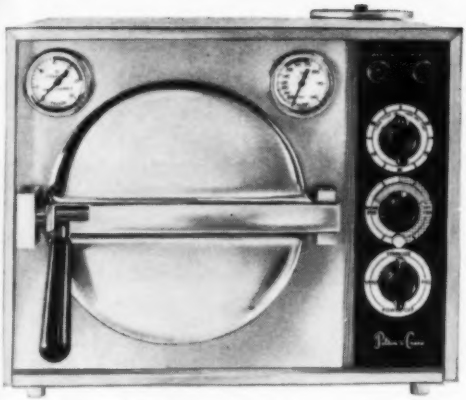
getting a fine bargain—as the British people do.

In England a few months ago, I was struck by the number of Britons who go about their business under the cheerful delusion that the National Health Service is *free*. Less cheerful are the doctors. I talked with a cross-section of family physicians in five British cities. Most exuded hopelessness, apathy. Earlier frustration has given way to resignation. And why not? They're told where they may and may not practice. To some extent, they're told *how* to practice. And on Britain's economic totem pole they're a lot too close to the bottom for comfort.

Since many people in the U.S., as well as in Britain, favor compulsory national health insurance, the question is: How can private American doctors compete with this medical pie-in-the-sky? I'm sure of one



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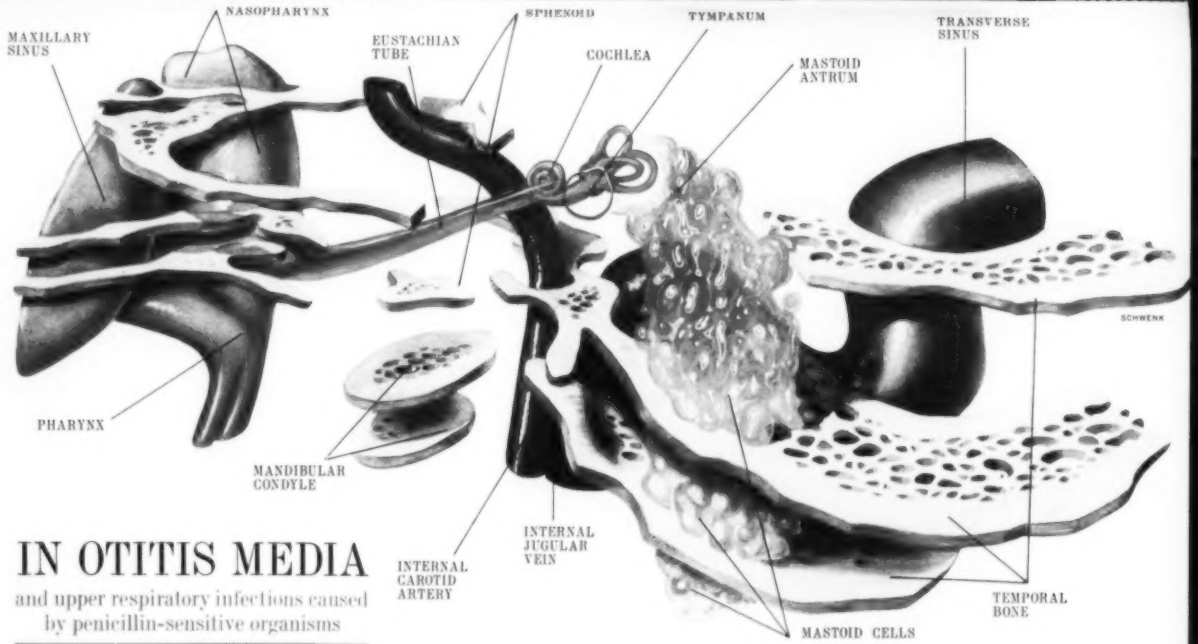
Government's threat to your private practice is represented in the bill that carries the names of these two Democratic legislators—Rep. Cecil King of California (left) and Sen. Clinton Anderson of New Mexico. Their bill offers Congress the President's blueprint for Social Security-financed medical care for the aged.

thing: It's not enough to fight defensively. Medicine in this country must come up with a positive alternative. What alternative? My answer: *better* VOLUNTARY *health insurance.*

The nation's voluntary physician-service and hospital-service plans must consolidate. They must offer, among other things, a full, uniform program of health benefits, coast to coast. Blue Cross has begun to unify itself. Soon, in all fifty states, it will offer wide benefits to national accounts (unions, corporations, et al.). Blue Shield must do the same.

But unifying the Blue plans is only part of the job. They and the commercial plans must also work together more closely.

At the same time, such plans must find a way to let medical services be given to insured patients not only in the hospital



This diagram represents the lateral aspect of the left middle ear and related structures. The bony landmarks are shown in serial sections.

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Medi

but a
office,
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tends

but also in the home or medical office, at the doctor's discretion. Limiting physicians' services to the hospital, as is now the custom among voluntary plans, tends to overutilize hospital beds and boost patient-care costs unconscionably.

Now consider the threat to private medicine posed by *hospitals:*

By 1970, the hospital will be

What Blue Cross is doing to achieve a united front

The author tells of Blue Cross' drive for unification and of Blue Shield's passivity. This is how things stand:

Blue Cross has been reorganized to bring it under A.H.A. control. It intends:

To create a unified Blue Cross plan offering identical benefits for identical premiums in every state.

To expand coverage to include, for example, out-patient radiology.

To offer full service benefits to all subscribers regardless of their means.

Blue Shield has not progressed toward internal consolidation. It's still characterized by:

Local autonomy and wide variations in premiums, eligibility, and benefits.

Limited coverage, mainly indemnity-type.

Strong resistance in some areas to service benefits.

These are the roadblocks: The A.M.A. wants to work with commercial carriers; the A.H.A. doesn't. Blue Cross wants centralized control; Blue Shield doesn't.

Interim result: Three "united fronts"—the A.M.A. and the commercial carriers; the A.M.A. and Blue Shield; Blue Shield and Blue Cross.

Outlook for consolidation: Cloudy, with thunderstorms.

the chrome-plated hub of the medical community—a latter-day center of local medical organization and operation, offering omnibus services for diagnosis and treatment. Just as many anesthesiologists, radiologists, and pathologists have already become captives of the hospitals they serve, so also will members of many of the other specialties.

As time passes, more and more clinical procedures will re-

House staff shortages imperil attendings' status

The dearth of internes and residents can be a potent weapon in the hands of hospital administrators bent on bringing medical staffs to heel, says the author. They'll push the idea of hiring full-time specialists, thus freezing out many self-employed attendings. Here are the facts:

There are 6,845 U.S. hospitals; 1,438 have A.M.A.-approved internes and/or resident training programs; 5,407 do not have approved programs.

The number of hospital beds in each group is equal. In other words, half of all the hospital beds in this country are in hospitals without approved programs.

In the 1,438 hospitals that have approved programs, 44,000 positions are available, but only 37,800 are filled. This leaves 6,200 positions vacant.

Some 2,500 foreign doctors recently flunked their qualifying exams. If they're fired, total vacancies will rise to 8,700.

In the 5,407 hospitals without approved programs, no official figures on vacant interneships and residencies are available. But it's known that the vacancies that do exist are filled only on a hit-or-miss basis.

Half the hospital beds in the U.S. are in hospitals that lack their proper complement of house officers.

Percodan tablets effectively relieve pain through a range of

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Also available—for greater flexibility in dosage—PERCODAN®-DEMI: The PERCODAN formula with one-half the amount of salts of dihydrohydroxycodeinone and homatropine.

LITERATURE AVAILABLE ON REQUEST

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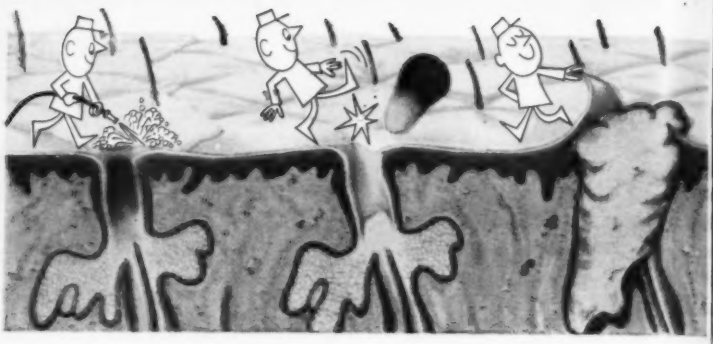
*U.S. Patent Nos. 2,628,188 and 2,907,768



Fostex® treats pimples·blackheads·acne while they wash

degreases the skin
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Patients like Fostex because it's so easy to use. Instead of using soap, they simply wash acne skin with Fostex Cream or Fostex Cake 2 to 4 times daily.

Fostex contains: Sebulytic® base (unique, penetrating, surface-active combination of soapless cleansers and wetting agents*) with remarkable antiseborrheic, keratolytic and antibacterial actions . . . enhanced by micro-pulverized sulfur 2%, salicylic acid 2% and hexachlorophene 1%.

***sodium lauryl sulfoacetate, sodium alkyl aryl polyether sulfonate and sodium dioctyl sulfosuccinate.**

Fostex Cream and Fostex Cake are interchangeable for therapeutic washing of the skin. Fostex Cream is approximately twice as drying as Fostex Cake. Supplied: Fostex Cake—bar form. Fostex Cream—4.5 oz. jars. Also used as a therapeutic shampoo in dandruff and oily scalp.

And . . . since continuous 24-hour drying and peeling of acne skin is essential, FOSTRIL (a new, flesh-tinted drying lotion) should be used once or twice daily in addition to Fostex therapeutic washings. Fostril® contains Liposec® (polyoxyethylene lauryl ether), a new, surface-active drying agent used for the first time in acne treatment. This agent, with 2% micropulverized sulfur and a zinc oxide, talc and bentonite base, provides Fostril with excellent drying properties. Fostril also contains 1% hexachlorophene.

Available: Fostril, 1½ oz. tubes. Fostril-HC (¼% hydrocortisone) 25 gm. tubes.

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uire the costly equipment that nly an institution can afford. ncreasing numbers of ambuant patients will then be sent o hospitals for cast applicaions, physical therapy, X-rays, ab work, and investigative proedures of all kinds.

Along with this growing use f hospitals could come growing ontrol over the physician. hat's the danger.

Even now, the hospital is visbly invading the doctors' territory. But doctors have found hat they *can* defend themelves. For example: Some prossional staffs have watchdog mmittees to make free-wheelng administrations think twice efore stepping on professionl toes. Some medical societies ave set up similar committees o hear and get corrective action n grievances against hospitals, odged by their society memers.

In Britain, the entire specialst service for 50,000,000 peole is an adjunct of the hospital. Attending staffs are simply unnown. If you're a specialist, ou apply for a salaried job in hospital. There's no other way. And unless the American medical profession is vigilant in its own behalf, that's how it may be here in time.

The third force barreling down on today's doctor is the *labor union*: Labor thinks doctors make too much money. Labor wants to abolish the fee-for-service physician. Many unions support panel medicine.

What can private doctors do about this? They can convince the unions that private medical care is better than panel medical care and that a personal physician can outperform a faceless medical mill seven days a week, fifty-two weeks a year.

And that brings me to the

Put your low-back patient back on the payroll

Soma's prompt relief of pain and stiffness can get your low-back patients back to work in days instead of weeks

Soma is unique because it combines the properties of an effective muscle relaxant and an independent analgesic in a *single drug.*

Thus with Soma, you can break up both pain and spasm fast, effectively . . . help give your patient the two things he wants most: relief from pain and rapid return to full activity.

Soma is notably safe. Side effects are rare. Drowsiness may occur, but usually only with higher dosages. Soma is available in 350 mg. tablets.

USUAL DOSAGE IS 1 TABLET Q.I.D.

The muscle relaxant with an independent pain-relieving action

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Wallace Laboratories, Cranbury, New Jersey

How you can help save your patients a month's pay

Kestler reports in J.A.M.A. (April 30, 1960) that conventionally treated low-back syndrome patients required an average of 41 days for full recovery (range: 3 to 90 days). The addition of Soma therapy in this comparative investigation reduced the average to 11.5 days (range: 2 to 21 days). With Soma, patients averaged full recovery 30 days sooner.

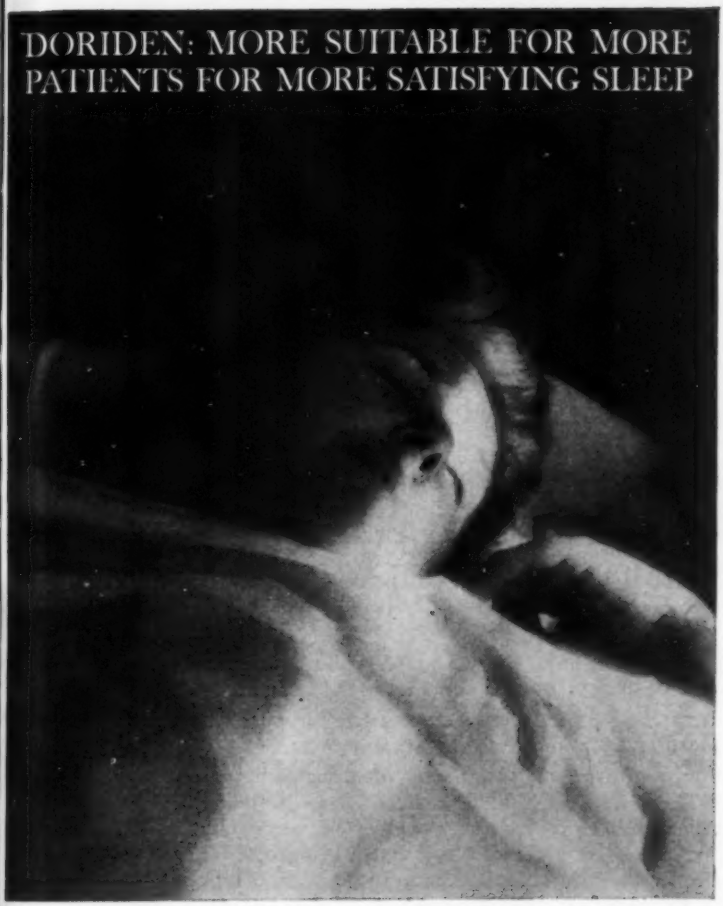
fourth force advancing on private physicians—the *public:*

We know that neither the Government nor the hospital nor organized labor can kill the private practice of medicine without the support of the public. So how can the doctor influence the public not to give that support?

Not long ago MEDICAL ECONOMICS surveyed the things that worry doctors most. Number one on the list was the deterioration of the doctor-patient relationship. It's often been said that most people think well of their individual doctor but take a dim view of the profession collectively. They feel toward organized medicine about as they feel toward their phone company: They like Joe, the repairman, all right. But they wouldn't give a hoot if the Bell system as a whole were nationalized tomorrow.

An A.M.A. study in 1955

DORIDEN: MORE SUITABLE FOR MORE PATIENTS FOR MORE SATISFYING SLEEP



Doriden offers sound, restful sleep for patients who are sensitive to barbiturates, elderly patients, patients with low vital capacity and poor respiratory reserve and those who are unable to use barbiturates because of hepatic or renal disease. Onset of sleep with Doriden is smooth and gradual, usually with no preliminary excitation. Doriden acts within 30 minutes, and sleep lasts for 4 to 8 hours. Except in rare cases, no "hangover" or "fog," because Doriden is rapidly metabolized. SUPPLIED: *Tablets,* 0.5 Gm., 0.25 Gm. and 0.125 Gm.

Complete information sent on request.

/ORIDEN®

(glutethimide CIBA)

CIBA SUMMIT, N. J.

SIMMONS INVENTS A NEW MATTRESS—BACK CARE WITH BUILT-IN BEDBOARD

For firm support—the new-type bedboard, centered in the mattress, close to the back, firmly supports spinal structures.

For "sag" control—lower layer of springs pushes up against the bedboard and prevents "sagging" at any point.

For comfort—the upper layer of springs adjusts to body contours.

The unique construction of Back Care—including the new "Ortho-Fiber" bedboard—was suggested by physicians and has been tested and approved by leading orthopedic surgeons. They found that it affords patients both the firmness and the comfort necessary to alleviate backache caused or aggravated by lack of proper mattress support.

Many physicians endorse Back Care With Built-In Bedboard, as a basic adjunct to the management of chronic, uncomplicated backache.

For complete information—write for the descriptive booklet which is available from Simmons Co., Dept. AA, Merchandise Mart, Chicago, Ill.

For back problems not severe enough for an orthopedic mattress, extra-firm Beautyrest® provides ideal support and comfort.

BACK CARE by SIMMONS

showed that 30 per cent of Americans believed most doctors (1) were out to get rich quick, (2) collected commissions from druggists, (3) split fees, and (4) recommended unnecessary operations. Fifty-four per cent believed that doctors tried to hide each other's mistakes.

The layman's image of the M.D.—whether true or false—is what controls his behavior toward the profession. So don't laugh off the warning of motivation researchers who find a correlation between doctors' dwindling popularity and the talk about Government medical care.

If—as these signs seem to indicate—the medical profession has fallen into public disesteem, now is no time to wring rubber-gloved hands. It's a time to rebuild the crumbling pedestal.

The watchword is *organiza-*

tion. Doctors need to organize:

¶ An adequate, unified, nation-wide voluntary health insurance complex.

¶ An integrated program to avert hospital domination and assure continued professional independence.

¶ A plan to meet every valid criticism leveled at private medical care by its opponents.

Prussia's great military stra-

Amusing . . .
Amazing . . .
Embarrassing . . .

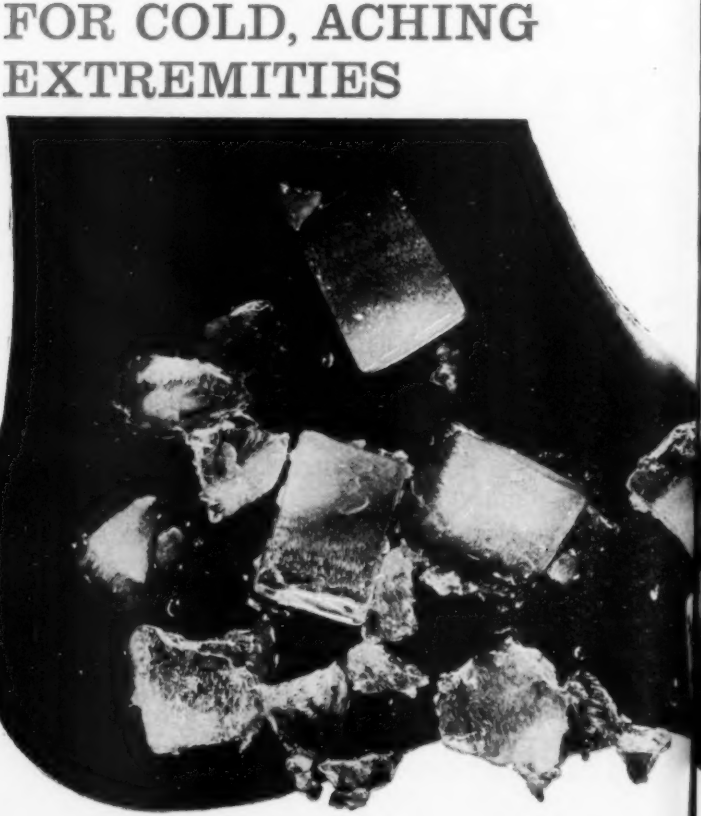
No doubt one of these adjectives describes some incident that has occurred in the course of your practice.

Why not share the story with your colleagues?

If it's accepted for publication, you'll receive $25-$40.

Contributions must be unpublished. They cannot be either acknowledged or returned. Those not accepted within ninety days may be considered rejected. Address: Anecdote Editor, MEDICAL ECONOMICS, Oradell, N.J.

WHAT'S NEW AND SPECIFIC FOR COLD, ACHING EXTREMITIES



INCREASES AND MAINTAINS BLOOD FLOW FOR 10-12 HOURS

THAWS ICY HANDS AND FEET Roniacol Timespan promptly increases circulation in cold fingers and toes,[1] resulting in "less ischemic pain, improved pulses and increased skin temperature."[2] Action: specific dilation of peripheral vessels.[1] Result: Roniacol increases blood flow to ischemic extremities.[3-5] Improved blood flow further minimizes the chance of ulcerations associated with peripheral arterial insufficiency.

EACH DOSE ACTS FOR 10-12 HOURS New, sustained-release Roniacol Timespan provides convenience for your patients as well as daylong or nightlong relief of cold, aching extremities—one Timespan in the morning precludes forgotten midday doses, another at night permits comfortable, uninterrupted sleep.

NO CONTRAINDICATIONS—NEGLIGIBLE SIDE EFFECTS Unlike sympathetic blocking agents, Roniacol is selective—produces no cardiac stimulation, no hypotension, no gastrointestinal stimulation[6,7]—may be used safely in the presence of gastritis, peptic ulcer or coronary disease. Of 264 patients on Roniacol Timespan, only thirteen experienced side effects—none of them major.[1]

RONIACOL TIMESPAN tablets are recommended for convenience of therapy in conditions associated with deficient circulation; e.g., peripheral vascular disease, including generalized arteriosclerosis, cerebral arteriosclerosis, varicose ulcers, decubital ulcers, chilblains, diabetic endarteritis, Meniere's syndrome and vertigo due to impaired cerebral circulation.

DOSAGE: One or two Roniacol Timespan tablets in the morning and at night.

SUPPLY: Tablets of 150 mg, bottles of 50. When prolonged effects are not desired, prescribe Roniacol Tartrate Tablets, 50 mg, or Roniacol Elixir, 50 mg per teaspoonful (5 cc).

REFERENCES: 1. Reports on File, Roche Laboratories. 2. W. D. Westinghouse, Personal Communication. 3. E. C. Texter, et al., **Am. J. M. Sc., 224**:408, 1952. 4. M. M. Fisher and H. E. Tebrock, **New York J. Med., 53**:65, 1953. 5. I. H. Richter, et al., **New York J. Med., 51**:1303, 1951. 6. C. M. Castro and L. De Soldati, **Angiology, 4**:165, 1953. 7. R. M. N. Crosby, **Am. J. M. Sc., 225**:61, 1953. 8. J. Dosdos and G. E. Arnold, **Eye Ear Nose & Throat Month., 38**:1035, 1959.

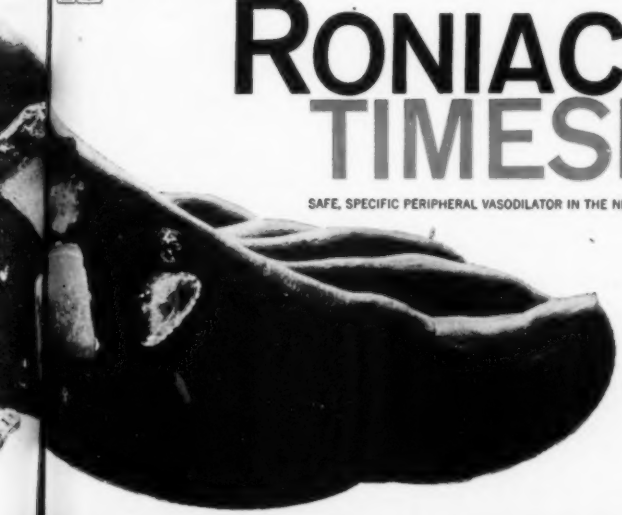
Roniacol® —brand of beta-pyridyl carbinol. Timespan®

ROCHE LABORATORIES • Division of Hoffmann-La Roche Inc • Nutley 10, N. J.

RONIACOL TIMESPAN

TABLETS

SAFE, SPECIFIC PERIPHERAL VASODILATOR IN THE NEW SUSTAINED-RELEASE FORM



tegist von Clausewitz taught that a well organized minority is always superior to an unorganized majority. *You* are a minority. And *you* can organize. If you don't, you'll have lost your chance to control your professional future.

The price of liberty is still eternal vigilance. END

Rx for rusty speech-makers: semiprivate practice

If a public-speaking invitation sends you into a panic, you're not the only doctor who reacts that way. A group of Binghamton, N.Y., physicians rated themselves such rusty speech-makers that they're now analyzing each other's oratorical ailments in a speech class for doctors only.

The twice-a-month class started soon after a former broadcaster took over as executive secretary of the Broome County Medical Society. "I wanted to reorganize our speakers' bureau," explains Michael W. McManus, "but I found that lots of doctors were turning down speaking invitations because

newest J.A.M.A. paper[1]

reports **DBI** *an*

"oral therapy of choice"

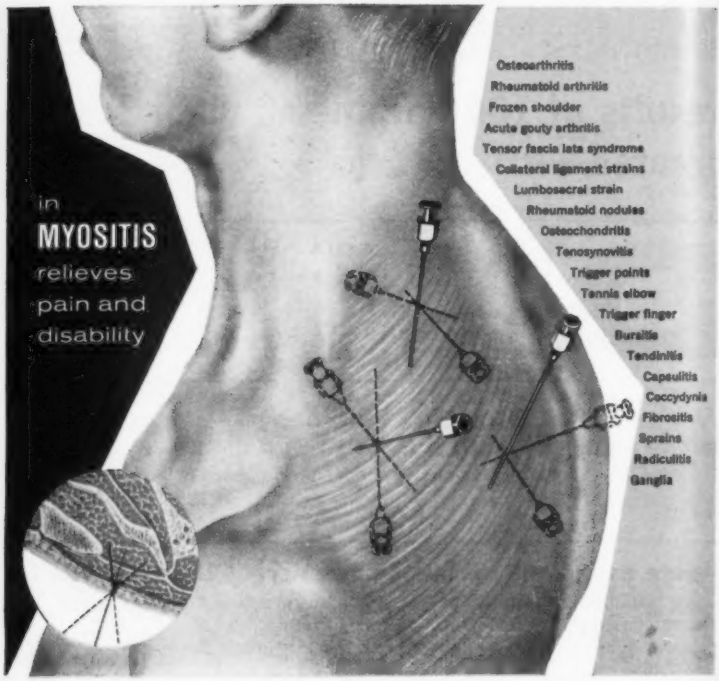
in management of diabetes..

from the mild stable adult

to the severe labile juvenile

DBI (brand of Phenformin HCl-N¹-β-phenethylbiguanide HCl) is available as 25 mg. white, scored tablets, bottles of 100 and 1000.

NOTE—before prescribing DBI the physician should be thoroughly familiar with general directions for its use, indications, dosage, possible side effects, precautions and contraindications, etc. Write for complete detailed literature.



SUSPENSION

HYDELTRA-T.B.A.®

PREDNISOLONE TERTIARY-BUTYLACETATE

CONSISTENTLY EFFECTIVE—PROLONGED RELIEF

Dosage: the usual intra-articular, intrabursal or soft tissue dose ranges from 20 to 30 mg. depending on location and extent of pathology.

Supplied: Suspension HYDELTRA-T.B.A.—20 mg./cc. of prednisolone tertiary-butylacetate in 5-cc. vials.

Additional information is available to physicians on request. HYDELTRA-T.B.A. is a trademark of Merck & Co., INC.

MERCK SHARP & DOHME
Division of Merck & Co., Inc., West Point, Pa.

they felt inadequate. So I offered to give speech lessons, and the doctors went for the idea. Even those who didn't want to take the course themselves thought it would be a good thing for the others."

By the end of the five-month series, each doctor in the class will have made about four speeches—with his classmates acting as critics. "We started by reading Dickens aloud and learning how to propose toasts and tell stories," McManus reports. "Toward the end, we'll get into extemporaneous speaking. We've been using a tape recorder so each doctor can mark his own progress."

What's the physicians' biggest speech problem? Getting enthusiasm into their voices. Says McManus: "Many doctors don't use any inflection. And no doctor can stimulate his audience if he doesn't speak in a convincing, enthusiastic manner."

How good is your public speaking? One way to check the impression you'll make is to try your technique in front of a mirror.

Go back to college? It's a good practice, he says

How would you like an eight-hours-a-day practice with intelligent patients and a two-month annual vacation? If this sounds good to you, then maybe you'd enjoy working as a student health physician in a college or university.

Here's how Dr. John LeValley of San Jose State College, Calif., describes his job:

"As one of nine full-time physicians on the campus, I have my own consultation room and two well-equipped examining rooms. I also have access to excellent X-ray, laboratory, and physiotherapy facilities. And you can't beat the hours! We work a forty-hour week with two months off in the summer. At night and on week-ends, students needing emergency care go to the town's private practitioners or hospital emergency rooms.

"Dealing with college students is a stimulating experi-

"A college is the ideal place to practice," says Dr. John LeValley. One reason: Most students make intelligent, cooperative patients.

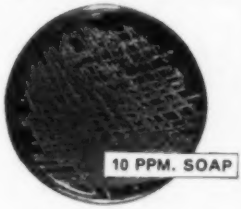
s aureus

patients suggested

infection in hospitals!

1355 W. 31st Street, Chicago 9, Ill.

In vitro tests demonstrate Dial's antibacterial superiority against Staph. Aureus



1. Ordinary toilet soap left this heavy Staph growth.

2. A widely used antiseptic soap showed little inhibition of Staph.

3. Dial Soap completely inhibited the growth of Staphylococcus aureus.

ence," says Dr. LeValley. "I've never seen a group so interested in medical problems. They seem to appreciate the attention they get, follow directions well, and return promptly for follow-up care. Most of them suffer from respiratory infections or minor trauma, but heart murmurs, infectious mononucleosis, and hepatitis are also fairly common.

"Of course," Dr. LeValley concedes, "student health physicians at $900 to $1,100 a month earn less than most doctors in private practice. But we don't have to worry about overhead costs or collection problems. And we do get a number of fringe benefits that private practitioners don't. For example, my college pays for my malpractice insurance and for part of my health and life insurance. It also contributes to a retirement plan that'll allow me to retire at 60 on a yearly income of half my highest annual salary.

"But the biggest fringe benefit can't be measured in dollars and cents," Dr. LeValley says. "It's the opportunity to live and work in an intellectual environment. It adds zest to my life and helps me keep abreast of the times." END

"All you have to do to clear up marital problems is to work as a team."

swing into action *with*

DESITIN® HC

hemorrhoidal

SUPPOSITORIES

with hydrocortisone

for fast relief of inflammation, pain, pruritus and edema (using 2 daily for up to 6 days)

in severely inflamed hemorrhoids proctitis, cryptitis, anal pruritus

follow through *with regular*

DESITIN®

hemorrhoidal

SUPPOSITORIES

to sustain comfort and promote healing ... they lubricate, decongest, ease defecation

both suppository formulas contain healing Norwegian cod liver oil; they do not contain astringents, anesthetics, or other drugs which might mask serious rectal disease

samples and literature from....

DESITIN CHEMICAL COMPANY
812 Branch Avenue, Providence 4, R. I.

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"All you have to do to clear up marital problems is to work as a team."

For the

e COMPENSATORY OVEREATER

Unhappy because she's gaining weight,
gaining weight because she's unhappy...

what a problem the compensatory overeater poses! She's a difficult patient to handle; diets are too demanding, willpower isn't enough.

You can help her help herself... and be sure of

CONTROLLED WEIGHT LOSS

by prescribing Biphetamine or Ionamin. The appetite appeasing action of these 'Strasionic' release products is uniformly prolonged for 10-14 hours with a single capsule dose.

If She's "Sedentary"

BIPHETAMINE®

'STRASIONIC' RELEASE ANORETIC RESIN

BIPHETAMINE '20'
(20 mg.)

PHETAMINE '12½' (12.5 mg.) **BIPHETAMINE '7½'** (7.5 mg.)

Each capsule of each strength contains equal parts of d-amphetamine and dl-amphetamine as cation exchange resin complexes of sulfonated polystyrene.

If She's "Active"

IONAMIN®

A 'STRASIONIC' ANORETIC PHENTERMINE RESIN

IONAMIN '30'
(30 mg.)

IONAMIN '15'
(15 mg.)

Each capsule of each strength contains phentermine as a cation exchange resin complex of sulfonated polystyrene.

Single Capsule Daily Dose 10 to 14 hours before retiring

STRASENBURGH

PEOPLE!

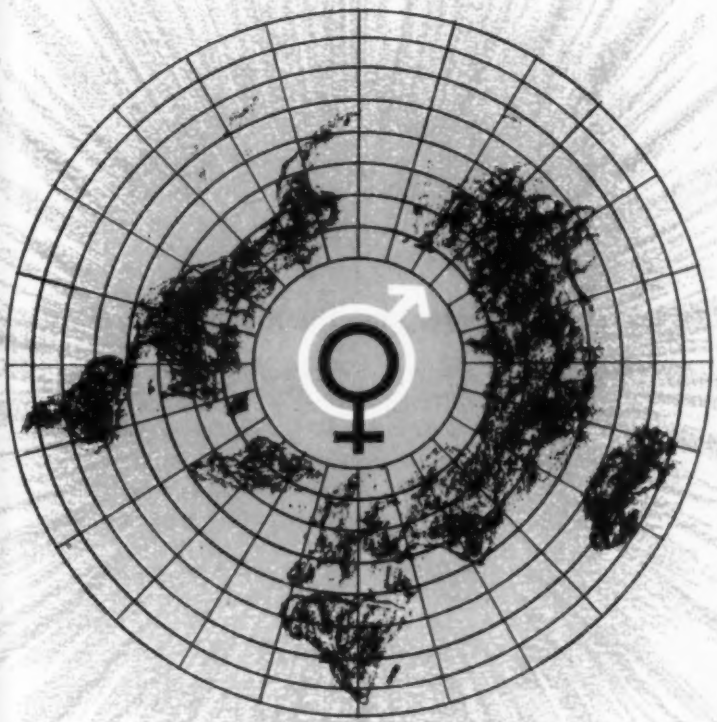
Challenge to survival

Condensed from the book
by William Vogt

There are more hungry people in the world today than ever before in the history of the human race. From Haiti and Bolivia to India and Indonesia and parts of Africa and China, the dearth of the good things of life is growing like the decay of leprosy. To travel through vast areas of the world inhabited by the majority of its people is to encounter misery so nearly universal and so harrowing as to be almost intolerable to us overstuffed Americans.

The cause? In large part, the world's population explosion.

This population change is having more of an effect on more people than has any phenomenon since the human ancestor began to walk upright. The very face of the earth is being ravaged by the rising hu-



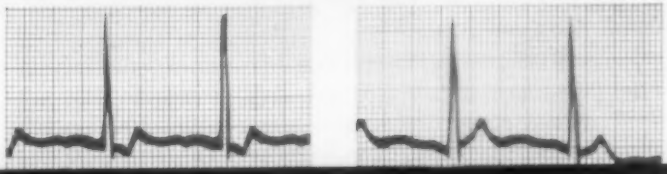
man flood. The standard of living of literally hundreds of millions is being lowered each year. And this deterioration is by no means limited to the underdeveloped countries. The changes that population growth is bringing about reach into every part of our lives, our workshops, our schools, our pantries, our kitchens, even the secret places where we make love. It is setting the stage for the final war

A danger greater than the H-bomb

Excessive population growth is "the most fateful problem of our day," says William Vogt, author of the book condensed here. "Every man, woman, and child in the world is feeling its pressure one way or another. Unless effective action—now not even in sight—is taken to solve this emergency situation, it could result in a particularly grim form of death for millions, and the end of civilization as we know it." He suggests some practical steps that he feels must be taken immediately to halt the world's population explosion. Author also of the best-selling "Road to Survival," Mr. Vogt is an internationally known ecologist and conservationist. He has long been a leader in the Planned Parenthood movement.

radiocardiography

supports



electrocardiography

Pentrate

make love. It is setting the stage for the final war

A danger greater than the H-bomb

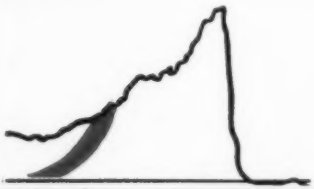
even in sight—is taken to solve this emergency situation, it could result in a particularly grim form of death for millions, and the end of civilization as we know it." He suggests some practical steps that he feels must be taken immediately to halt the world's population ex-

Now... 2 objective tests demonstrate that

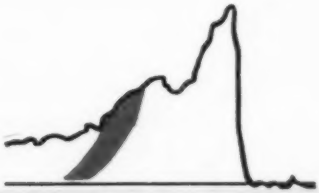
Peritrate produces a substantial and sustained increase in myocardial blood flow in patients with or without angina

Radioisotopic measurements show: In postcoronary patients, with or without angina, Peritrate increases myocardial blood flow "... beginning within one hour after ingestion and lasting up to five hours ..."[1]

Before **Peritrate**—Tracing shows reduced myocardial blood flow (red area) after infarction.[2]

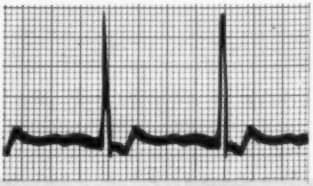


After **Peritrate**—Significant increase in myocardial blood flow of postcoronary patient.

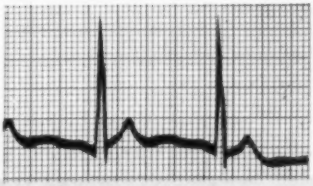


ECG response to standard exercise shows: A 20 mg. dose of Peritrate "... affords protection for four to five hours ..."[3]

Before **Peritrate**—Exercise ECG shows S-T segment depression.



After **Peritrate**—Exercise ECG shows normal S-T segment.



Peritrate is safe — causes no change in cardiac output,[1] no significant change in blood pressure or pulse rate.

Full dosage information, available on request, should be consulted before initiating therapy.

basic therapy in coronary artery disease
—with or without angina

Peritrate®

brand of pentaerythritol tetranitrate

makers of Gelusil Mandelamine Tedral Proloid

1. Johnson, P. C., and Sevelius, G.: J.A.M.A. 173:1231 (July) 1960. 2. Sevelius, G., and Johnson, P. C.: Use of Radioisotopes to Record Myocardial Blood Flow Changes Produced by Coronary Dilators, Scientific Exhibit, A.M.A. Meeting, Miami, Fla., June 1960. 3. Russek, H. I.: Postgrad. Med. 19:562 (June) 1956.

or, if that is avoided out of sheer terror, for a series of small wars that may eclipse in horror anything the human race has ever known. It is the greatest revolution in the history of mankind. And mankind has never before responded with such consummate stupidity and apathy to any threat that was so widely recognized.

Not a single government in the world can be said to have a considered population policy, though the Asians, not shackled by the peculiar superstitions of the West, have been on the brink of doing something about it. Government leaders throughout much of the world have come to recognize the existence of a human population explosion. Yet they act as though they had no more power of controlling it than of controlling an eclipse.

Meanwhile, time is running out. We may already have reached the point of no return. Ghastly famines are a virtual certainty. Perhaps nothing less will shake our leaders out of their timidity and complacency.

The so-called vital revolution began thousands of years ago with the slight drop in death rates resulting from improved living conditions. It really headed down the runway after Pasteur and Ross began to understand the basic mechanisms of disease transmission. And it took off for the wild blue yonder with the arrival of antibiotics and other "miracle" drugs, as well as new insecticides. Countries that in 1940 had the same death rates as the British Isles three hundred years ago slammed them down to the current British level in ten years. In a num-

first choice for MIGRAINE
recurrent, throbbing "sick" headaches...

CAFERGOT

When the headache is associated with nervous tension and G.I. disturbance:

CAFERGOT P-B TABLETS: ergotamine tartrate 1 mg., caffeine 100 mg., Bellafoline 0.125 mg., pentobarbital sodium 30 mg. Dosage: 2 at first sign of attack; if needed, 1 additional tablet every ½ hour until relieved (maximum 6 per attack).

CAFERGOT P-B SUPPOSITORIES: ergotamine tartrate 2 mg., caffeine 100 mg., Bellafoline 0.25 mg., pentobarbital sodium 60 mg. Dosage: 1 as early as possible in attack; second in 1 hour, if needed (maximum 2 per attack).

CAFERGOT TABLETS: ergotamine tartrate 1 mg., caffeine 100 mg. Dosage: same as Cafergot P-B Tablets.

CAFERGOT SUPPOSITORIES: ergotamine tartrate 2 mg., caffeine 100 mg. Dosage: same as Cafergot P-B Suppositories.

For a new brochure on Migraine and Tension Headaches, reviewing clinical reports on diagnosis and therapy, write: Sandoz, Hanover, N. J.

SANDOZ

1961

ber of countries where malaria was the most effective check on human numbers a mere two decades ago, the disease has been virtually wiped out.

Pointing out that population has been growing by 18 per cent a decade, Dr. Harrison Brown of the California Institute of Technology had this to say: "Let us assume that this growth continues decade after decade and century after century. At this rate, in 730 years"—closer to us in time than Magna Charta—"human beings will cover the land areas of the earth and will be so tightly packed that each of us will be able to own . . . estates [averaging] one square foot in area."

For Americans, an imaginative grasp of the problem is especially difficult. Don't we have the highest living standard in the world? Aren't we living a little longer each year? Although our food somehow costs more each year, we have so much of it we can hardly find a place to store it. What have we to worry about?

The answer is that we are not living in isolation on a rich island on this planet. We make up only about 7 per cent of the world's population. It is above the other 93 per cent that the mushroom cloud towers most threateningly. It is these people who are doubling their numbers not every forty-odd years as we are, but every thirty or even twenty years. And much of this doubling might not take place if it were not for a number of things we Americans do. On top of the problems we are creating at home, we are piling problems around the world.

This year, and next year, and the year after that,

for relief from the total cold syndrome...

Tussagesic*

timed-release tablets/suspension

Each Tussagesic timed-release Tablet provides:

TRIAMINIC®	50 mg.
DORMETHAN (brand of dextromethorphan HBr)	30 mg.
TERPIN HYDRATE	180 mg.
APAP (acetaminophen)	325 mg.

Dosage: *Adults and children over 12*—one tablet in the morning, midafternoon and at bedtime. Each tablet should be swallowed whole to preserve the timed-release action.

Each tsp. (5 ml.) of Tussagesic Suspension provides:

TRIAMINIC®	25 mg.
DORMETHAN (brand of dextromethorphan HBr)	15 mg.
TERPIN HYDRATE	90 mg.
APAP (acetaminophen)	120 mg.

Tussagesic Suspension is especially suited for children and for adults who prefer liquid medication; it is pleasantly flavored, non-narcotic and non-alcoholic.

Dosage (to be taken every 3 or 4 hours): *Adults and children over 12*—1 or 2 tsp.; *Children 6 to 12*—1 tsp.; *Children 1 to 6*—½ tsp.; *Children under 1*—¼ tsp.

*TRADEMARK

1961

DORSEY LABORATORIES • a division of The Wander Company • Lincoln, Nebraska

considerably
less
tense

BUTISOL SODIUM®
butabarbital sodium

"was found to be the most effective sedative which will produce satisfactory daytime sedation... with minimal occurrence of untoward reactions."[1]

. . . . but still keen-eyed and alert

BUTISOL sodium®

butabarbital sodium

In a five-year study[2] of representative sedative and ataractic agents, BUTISOL SODIUM provided the highest therapeutic index (per cent of effectiveness: per cent of untoward reactions) for control of anxiety and insomnia by daytime dosage.

"The therapeutic index as defined in this study reflects clinical usefulness and indicates to what degree a sedative agent approaches the ideal."[2] It is significant that phenobarbital, although widely used in anxiety states, falls far short of the ideal.[2]

BUTISOL SODIUM® Tablets
Repeat-Action Tablets
Elixir/Capsules

McNEIL

McNEIL LABORATORIES, INC., Philadelphia 32, Pa.

1. Grossman, A. J., Batterman, R. C., and Leifer, P.: Comparative Testing of Daytime Sedatives and Hypnotic Medications, Fed. Proc. 17:373 (March) 1958.

2. Batterman, R. C., Grossman, A. J., Leifer, P., and Mouratoff, G. J.: Clinical Re-evaluation of Daytime Sedatives, Postgrad. Med. 26:502-509 (October) 1959.

some 100,000,000 babies will be born. About half as many people (unless there is a war, a pandemic, or a major famine) will die. This will leave about 50,000,000 new people a year.

How many are 50,000,000? How fast are they arriving? It will help to understand if you will count your pulse for a few seconds. Assuming that you have a normal pulse beat, it will not quite keep up with the increase in world population, with the growth in numbers of empty stomachs. Every time your pulse throbs, the population of the world will have added more than one human being.

Before 1975, the entire world will begin to feel the real impact of the baby boom of the Forties and Fifties. By 1975, we will probably have a population in this country of around 225,000,000, instead of 180,000,000. This sudden addition of millions of people is certain to have an impact on every one of us alive in 1975, an impact that will be direct, personal, and acutely felt in day-to-day living.

What will our highways look like in 1975? The 65,000,000 motor vehicles registered in 1956, if driven on the same road, would have filled ten lanes bumper to bumper around the earth at the equator. We would have needed eighty-seven lanes bumper to bumper, New York to Los Angeles, merely to park them. There were about 10,000,000 highway accidents in 1956, killing almost 40,000. In 1975, this number of highway deaths may well jump to 51,000.

Unless life is to be one long traffic jam, ways will have to be found of staggering road use—which means a great change from the 9-to-5 day, plus the

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construction of thousands of miles more roads. Some superhighways cost around $3,500,000 per mile. If you spend dollars for roads, you won't have the money to spend for other things.

Superhighways use up some forty acres per mile, usually of good agricultural land. This loss, plus that caused by erosion, plus that needed for airfields, cities, recreation, reservoirs, flood control, and other purposes, will mean a sizable shrinkage in available farm land. To maintain food production for 25 per cent more people on 7 per cent less land will require much more intensive agriculture. This will make food rise in price even more rapidly than during the past several years.

Farmers depend more and more on irrigation; yet water is already a scarce resource in many parts of the country. Cheap fresh water from the sea will probably not become available in the next fifteen years, or even forty. Agricultural users will be likely to find themselves running short, and many towns and cities may well be rationed.

Meanwhile, the more people we have, the more government we must have. Between 1919 and 1956, our population rose 73 per cent. But the number of people on the U.S. Government payroll went up a whopping 166 per cent. This does not include city and state employes and the county courthouse gang. Obviously, when government costs jump from around $3.5 billion a year to $65 billion, it's going to take a whale of a lot more people to get rid of that money and to collect it. With roads jammed with cars, skies filled with jets, and schools over-

stuffed with children, personal freedom of action must shrink.

This process of an exploding population is not going to be a cheap one. There will be lots of new customers; but for at least the first twenty years of their lives, they are going to be living at the expense of somebody else. One of those somebodies is going to be you. In 1957, every worker supported 23 per cent more dependents than in 1946. Yet here the term "supported" is misleading. Government policy subsidizes large families in so many ways by tax forgiveness, schooling, free meals, free clinic services, etc., that it is now the taxpayer who largely supports the children in most families, after the second child.

It has been traditional to think of people as economic assets, one reason being that they were producers. But we have more producers now than we need; around 5 per cent of them are unemployed; and it is forecast that in this decade jobs will have to be provided for an estimated 13,500,000 *new* workers. With the spread of automation, many more jobs are going to disappear. Labor already has plans to spread the work thinner, to have each man work shorter hours in order to avoid unemployment. In other words, with millions of workers coming into the market each year as a result of the baby boom, we may not only have considerable numbers of unemployed directly subsidized by the taxpayer; there will be millions of hidden unemployed, partial featherbedders, paid for by the consumer.

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1965 one-half of all the children born in New York City will be in indigent families. New York, like a number of American cities, has for years been going into the red. It owes more than $4 billion. Its schools, parks, streets, transit and water systems, and hospitals have been deteriorating for sheer lack of funds.

In 1956, the U.S. Public Health Service estimated that we were 1,124,000 hospital beds short. At current costs, merely to catch up would require the expenditure of more than $19 billion. But a much greater problem than buildings is people. To build a hospital is simple, if costly. But to man it with the highly trained physicians required by today's medicine cannot be done merely by appropriating dollars.

We now have 132 doctors for each 100,000 of the population. To maintain this ratio to 1970 will necessitate the construction of fourteen to twenty new medical schools at a cost of between half a billion and a billion dollars. Then we shall have to find outstanding faculties to man them. There is plenty of room for improvement in our medical care today. Is it likely to take place under these conditions?

In 1958, there were about 44,000,000 school children. At the recent rate of increase, this school enrollment by 1975 will jump to 65,000,000. It would be hard to do more than guess how much the taxpayer will have to put up in the next fifteen years to meet the expected need. But classroom construction alone might well run in excess of $30 billion.

Because individuals' taxes are so largely con-

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cealed in one way or another, many of us have little idea what they are costing us in time as well as money. For example, in 1913 a man with two dependents and a $5,000 income worked only four hours to earn the Federal income tax he had to pay; in 1955, he worked four hours plus five weeks! This is quite apart from state and local taxes—income, property, school, etc. Our exploding population is going to send them up in the air, too.

Between 1900 and 1950, we doubled our population. Yet if we compare the latter year with the former, we were taking from the earth two and one-half times more bituminous coal, three times more copper, four times more zinc, twenty-six times more natural gas, and thirty times more crude oil. At mid-century, we were using about one-half of the entire world's non-food raw materials. If our population and economy continued to grow at its recent rate, it is estimated that by 1980 we should use 83 per cent of these raw materials.

All of which leads to a question: What right have you to have a child?

This is a direct question to every reader who is physically able to reproduce. It is a question that has been asked far too seldom. Indeed, the "right" to have children has been so uncritically accepted that various schools of busybodies who make a career of telling people what they are "morally" bound to do, have harped on man's *obligation* to reproduce.

What the imposition of life on the child may cost him seems to have been given little thought until very recent times. It is important to remember that *not*

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being born will make absolutely no difference to the child. It does not exist. It cannot miss anything—love, pleasure, happiness, or joy. Until the ovum is fertilized by the sperm, there is no life, no sentience, no possibility of deprivation.

Tens of thousands of children born every year in the U.S. should never have seen the light of day. These are the illegitimates, around 200,000 of them every year. Some are adopted by couples who cannot have children of their own. But most grow up in such a cloaca of poverty, ignorance, crime, and fright that a vicious circle perpetuates itself—in part through more illegitimacy. The crime is not the children's, but they are punished for it.

There are hundreds of thousands of others, technically legitimate, whose birth is as much of a crime against them as it is against the bastards. They are the unwanted. Their parents were too ignorant, too superstitious, or too irresponsible to see that children were not born.

It should be remembered that prior to the Christian era, there was safety in numbers, not only as a guarantee of carrying on the race but for protection against human and wild animal attacks. The idea that there is "safety in numbers" dies hard. It has survived into the contemporary credo of many of our economists, not to mention our businessmen. They seem to think that we can copulate ourselves into greater and greater prosperity.

Does the world need more babies at the present time? Does the U.S.? Does any particular family? Will the world, the U.S., and any particular family

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be in a better state after the birth of that last child than it was before?

Most intelligent people would accept the responsibility of every one of us toward the welfare of his fellow man. Unless we accept a "right is might" philosophy, we can scarcely justify actions on our part that will have deleterious effects on our fellow passengers on this crowded globe. And whether we like to face up to it or not, our having children—or not having them—is sure to have an impact on the lives of our fellow voyagers.

If we don't have an ethical justification for adding to the population ourselves, neither do we have a right to help the rest of the world do so. Some dozen years ago, when I suggested that foreign aid be limited to countries whose self-help included birth control, the attacks on me were vitriolic at home and abroad. I was accused of racism and fascism. In the succeeding years, our technical aid has been largely responsible for speeding up population growth from 55,000 a day to some 140,000. There are probably 500,000,000 more people competing for the limited supplies of food than there were in 1948.

It is said that a Chinese will not save the life of another, since by that act he becomes responsible for the man he saved. Are we not largely responsible to the hungry half-billion? Must we not in all conscience feel an obligation to ameliorate their lot? But are we going to continue to build up their numbers to the point where, like hordes of lemmings, they will dash themselves to destruction?

Have they a right to such unrestrained parent-

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hood? Have we Americans that right in an overpopulated world? What right has anyone today to have a child if that child is going to swell the world population? Should not all families limit their children at least to the number needed to replace themselves? This may be the most important question that could be asked in the twentieth century.

It should be clear that we are drifting down a current that can lead only to Maelstrom. Some readers will think that I am being unduly pessimistic. But I believe that men and women who have worked in the backward countries will generally agree with me. Some, like Sir Charles Galton Darwin, will even be so pessimistic as to conclude that disaster is inescapable. This conclusion I share, if we continue on our present inert way.

Obviously, birth control is not the sole answer to the population problem. There is need for a gargantuan expansion of improved land use, conservation of soil, water, forests, and grasslands. There is need for industrialization, education, capital investment, technical assistance, and the rest of the programs that have so long been discussed and so often badly applied.

The billions of dollars that have been spent in the underdeveloped countries have produced not much more than a holding action. In many cases, as in southeast Asia, more people are worse off today than they were before World War II.

For years now, the flow of babies has grown greater each year. It is time, if not to turn off the tap, at least to cut down the flow as much as prac-

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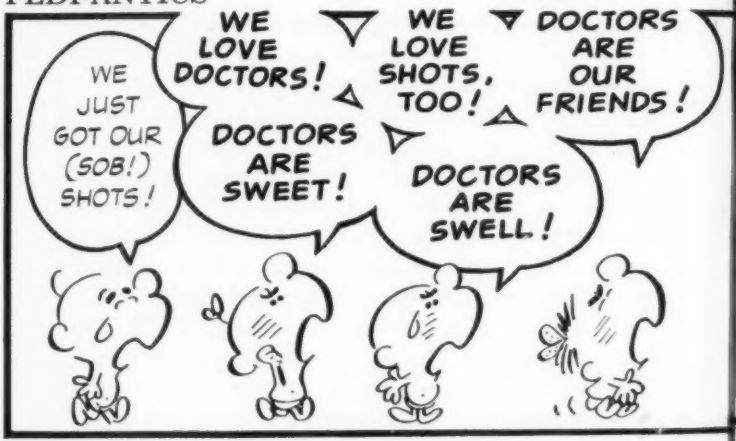

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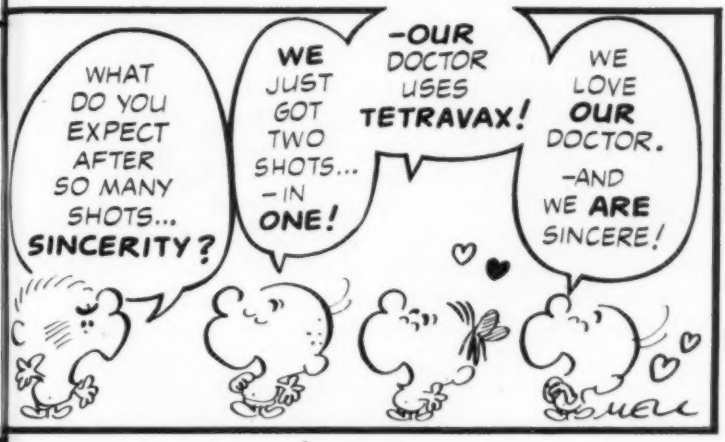

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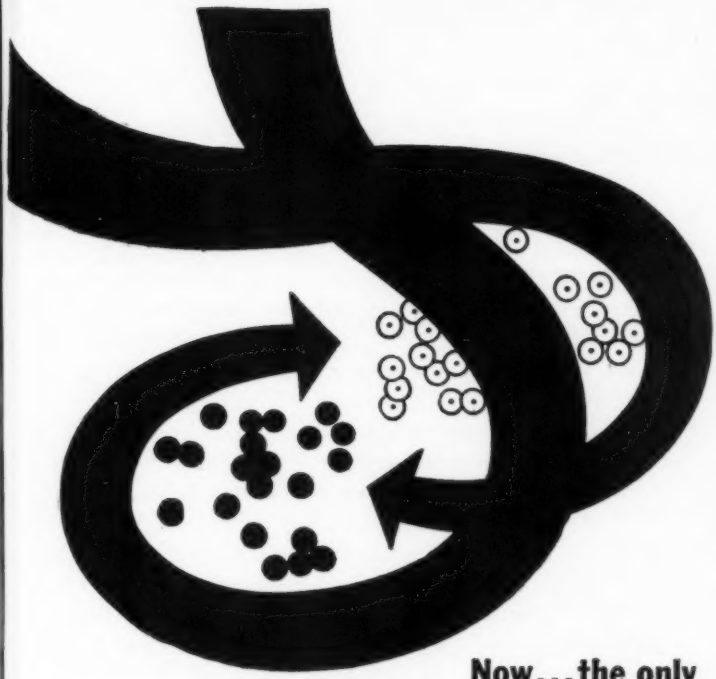
ticable. Probably the major obstacle in doing this is the Roman Catholic Church. But even the Roman Catholic position on birth control is far from monolithic. The Vatican has been liberalizing the reasons justifying the use of the rhythm method at such a rate that parish priests are often well behind the Pope. There is considerable ground for hope that a more rational attitude may be developed toward birth control for poor people overseas.

Not only should we give birth-control help to any country receiving health or economic aid from us; we should encourage birth control in other countries as freely as we would currency reform, agricultural improvement, flood control, or emergency food supplies.

We do not shrink from recommending changes in land inheritance and tenure, even when these may run counter to religious custom, if it seems necessary in improving agriculture, controlling erosion, and making irrigation possible. We do not wait to be asked before giving help in improving diet. When we make grants, we presumably require adequate accounting to make sure the money is not stolen. Why not, then, human accounting to insure that we do not build human populations into such liabilities that illiteracy and starvation are made an inescapable part of the future?

The realities of this situation would seem not only to dictate the inclusion of birth control in our foreign aid programs. We have been warned that to press birth control on any country would be politically disastrous. That I find hard to believe. The



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leaders of the emerging peoples are intelligent men and women. Learning the value of birth control is no more difficult than understanding the necessity of a currency that will be internationally acceptable, or the need for large amounts of fertilizers for exhausted lands. In the long range, with few exceptions, it will be only those underdeveloped countries that have cut their birth rates that will escape misery and chaos. Are we to shy away from the idea and let our programs to help millions of people collapse in a smoking ruin?

That the American people should help provide birth control to any country requesting it, and that it should inspire the acceptance of such a health measure just as it does malaria and yaws control, would seem obvious.

The population explosion is both more dangerous and more immediate than the H-bomb. The population explosion has already been triggered off. What are the possibilities of again getting it under control?

Given an unobstructed will, free of Roman Catholic opposition, with supporting funds amounting to a mere fraction of what is now being spent on space exploration, the possibilities are considerable. Scores of millions of men and women throughout the world would readily accept birth control were it available. In most societies (perhaps excluding Africa and some Moslems) the better educated and more prosperous groups have adopted birth control. Their example is important. It would probably not be unduly optimistic to assume that, were acceptable contra-

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Since ELASE provides, not a precursor, but an active enzyme,[1] it quickly lyses fibrinous material in serum, clotted blood, and purulent exudates. It does not, however, attack living tissue to any appreciable degree, nor does it have an irritating effect on granulation tissue in wounds.[1-6]

Good results have been obtained with ELASE in the debridement of infected surgical wounds.[1,6] Exudative lesions that have responded well include second- and third-degree burns, ulcerations, small gangrenous areas of the extremities, sinus tracts, fistulas, abscess cavities (including empyema), wounds, and pyodermas. Prompt and striking symptomatic relief has also been obtained in patients with gynecologic complications.[4]

SE (fibrinolysin and desoxyribonuclease, combined [bovine], Parke-). Dry material for solution, each vial contains 25 units (Loomis) fibrinolysin and 15,000 units of desoxyribonuclease with 0.1 mg. imerosal as a preservative. Ointment, tube of 30 grams containing nits (Loomis) of fibrinolysin and 20,000 units of desoxyribonu- with 0.12 mg. thimerosal in a special petrolatum base; tube grams containing 10 units (Loomis) of fibrinolysin and 6,666 of desoxyribonuclease with 0.04 mg. thimerosal in a special olatum ointment base. *Indications:* To lyse fibrin and liquefy pus. removal of necrotic debris associated with vaginitis and cervi- Useful in the removal of exudate from skin surfaces as in ts, ulcers, burns; also used to irrigate abscess cavities, super- hematomas, sinus tracts, fistulas. *Dosage:* Apply topically as ent or solution. Intravaginally—in mild to moderate vaginitis cervicitis, deposit 5 cc. of ointment deep in the vagina once y after retiring for five applications; re-examine for possible at further therapy. In more severe cervicitis and vaginitis, c. of solution may be initially instilled intravaginally, waiting two minutes for dispersal, then inserting a cotton tampon to moved the next day, followed by as many applications of oint- as necessary. Skin surface lesions—topically, as indicated. application, enzymatic activity becomes rapidly and progres- less and is probably exhausted for practical purposes at the of 24 hours. The ointment and dry material for solution are e at room temperature for a period of one year. *Precautions:* r parenteral use; bovine fibrinolysin may be antigenic. Side ts are minimal, consisting usually of local hyperemia. Observe precautions against allergic reactions, particularly in persons sensitive to materials of bovine origin.

GE INFORMATION: ELASE is supplied as an ointment in 30-Gm. 10-Gm. tubes. Disposable vaginal applicators (V-Applicators) for ation of ointment are available separately in packages of 6. E is also supplied as lyophilized powder in rubber-diaphragm- ed vials. To be maximally effective, the solution must be freshly nstituted with isotonic sodium chloride just prior to topical use. n six hours after preparation, half of its potency is lost at room rature.

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purulent amputation stump with osteomyelitis, left leg of 12-year-old boy.

Draining wound four weeks postoperatively and prior to enzymatic therapy. Infective organisms identified were Pseudomonas and coagulase-positive staphylococci.

Eight days later. Solution containing 50 Loomis units fibrinolysin and 50,000 units desoxyribonuclease applied topically, for periods of three hours 3 times daily, for seven days. Considerable improvement in fibrinopurulent base of stump.

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ceptives cheap and available, at least half the families in the world would make an effort to limit the size of their families.

The availability of hundreds of millions of contraceptives, either at a nominal, subsidized figure or free of cost, would almost certainly result in widespread use. The improved living standards that would result from smaller families should prove the most effective education on the advantages of birth control.

The next three or four decades are likely to prove critical. Unless population growth can be significantly reduced within that period, a number of countries and, indeed, entire regions will probably not be able to pull back from disaster. Economic, political, and cultural development will not be able to keep up with the rising demand. The population wave will rise until it breaks in famine, revolution, perhaps spilling across international borders into local wars or even general war.

The price in human misery will be horrible. Whether we of the temporarily prosperous West can escape being caught in the backwash will depend on many and unpredictable factors.

That we are morally involved is widely agreed. That we have a responsibility to help the underdeveloped nations is also recognized. What is not generally recognized is that we also have a responsibility to set an example. With something like one-sixteenth of the world's population, we are using more than one-half of the world's raw material. We get it simply because the poor countries desperately need what we

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1. Barden, F. W., et al.: J. Maine M. A. 46:99, 1955.
2. Ford, R. A., and Blanchard, K.: Journal-Lancet 78:185, 1958.

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have to barter. The raw materials we buy today—iron ore, non-ferrous metals, oil, topsoil—may be a matter of life and death twenty or thirty years hence, if these poor countries have been able to develop and to escape famine. By then, many of them will have doubled populations. Can we defend the right to deprive tomorrow's child?

Many leaders in the West, though still not enough, have begun to recognize and recommend the necessity of cutting birth rates. Yet ours in the U.S. remains relatively high. Our population is doubling at about the same speed as that of India.

Does there not lie upon us the categorical imperative to act as we urge others to act? In a world that is being swamped by people, do we have any right to increase the human cargo? Should we not as a matter of principle and example limit our reproduction to replacement, or even a little less?

These are not easy questions, nor are we likely to find simple answers. But there is no rug under which we can sweep the questions. They are with us now, and they will be even more omnipresent tomorrow. Every one of us should go back to pulse-counting, as a reminder of what is happening, as a sort of population rosary.

There are almost 100 more people a minute, 6,000 the hour, 140,000 the day, 50,000,000 the year! They cannot be wished out of the world. They must be lived with. And by the time our children are middle-aged, there may be twice as many of them—perhaps increasing even faster. Time is running out.

Almost 100 more every minute . . . END

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DICATIONS: Urobiotic is indicated in e treatment of a number of common nitourinary infections caused by susptible organisms. It may also be used ophylactically before and after genirinary or pelvic surgery, following strumentation procedures, during the e of retention catheters, and in patents with conditions such as cord ladder or cystocele.

SAGE: In adults, a dose of 1 or 2 capules four times daily is suggested, pending upon the severity and reponse of the infection. In children 60 100 lbs., the suggested average dose 1 capsule four times daily; in chilen under 60 lbs., 1 capsule three times ily. Therapy should be continued for minimum of 7 days or until bacteriogic cure is effected in acute urinary act infections.

NTRAINDICATIONS: Urobiotic may be ntraindicated in patients with chronic omerulonephritis, hepatitis, hepatic ilure, uremia, and obstructive lesions the urinary tract, and should not be ed in patients sensitive to any of its mponents.

RECAUTIONS: The use of broad-spectum antibiotics may, in rare cases, reult in an overgrowth of nonsusceptible rganisms, such as monilia or staphycocci. Should such superinfection cur, therapy with Urobiotic should be scontinued and specific therapy instited as shown by susceptibility testing. he use of sulfonamides may cause renal ystalluria or skin rash, as well as other xic or sensitivity reactions. If any of ese occur, discontinue use.

PPLIED: Urobiotic capsules, yellowd-grey, bottles of 50.

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Medical Economics, Mar. 27, 1961

...Your world

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Your medical society may keep track of the free medical care you and your colleagues give, but your patients probably don't hear about it. That is, unless you live in Louisville, Ky., and your patients use one of the three pharmacies owned by Fred B. Kluth.

Druggist Kluth is one of the best public relations men a doctor could have. His prescriptions are accompanied by a card headlined: PHYSICIANS GIVE FREELY. Quoting a national survey showing that private practitioners give $658,000,000 in free care annually, he comments that more than 98 per cent of all physicians give such care.

The volume of this care, Kluth points out, "is so great that it exceeds [in value] the Federal-state program of medical care for the elderly recently legislated by Congress." He concludes: "May we also point out that U.S. medical men have invariably donated their professional services without compulsion—and without seeking public applause." END


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Memo from the editors

Medical Economics, March 27, 1961

How typical are you?

While you've been reading this issue of MEDICAL ECONOMICS, more than 127,000 other physicians have been reading it too. From our latest personal and professional data on them, we've just drawn a composite portrait. Take a look at our typical reader and see how much of yourself you recognize in him.

He's 47 years old. Married at 26, he and his wife now have three children—the oldest already in college, the other two in public school. The family lives in an eight-room house that cost $35,000, and the doctor supports them on an after-tax net income of $18,900 a year. He loves his wife but complains occasionally about her extravagance.

He loves his profession too. He works sixty hours a week at it—ten, twelve, or more hours a day. He takes care of twenty to twenty-five patients daily, or about 6,500 visits a year. He drives 17,000 miles annually from home to office to hospital to house calls. He skimps on breakfast, gulps his lunch, stuffs down too much dinner. Perpetually tired, he gets no more than seven hours' sleep a night. But he hasn't missed a day's work because of illness for at least a year.

His three greatest worries—and he doesn't have time to brood about them often—are doubts about whether he's rearing his children right, the drift toward socialism in the U.S., and the difficulty of saving enough to retire on. Without a tax-favored pension plan or Social Security, he doesn't think he'll ever retire completely from medical practice.

He's just a bit worried about his weight (170); he's been on and off a diet. He smokes less than he used to (less than one pack a day) and drinks moderately (never more than one drink on week-nights). He may play golf occasionally, or possibly bridge, but his main after-hours interest is reading. And he reads MEDICAL ECONOMICS more than he reads any other magazine—more than Life, Time, the Journal A.M.A., or any other publication except his daily newspaper. END

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